HOSPITALS

special planning and construction issue

MARCH · 1955

The Journal

"...a potent antihemorrhagic factor"*

in use in more than 2500 hospitals

Adrenosem controls capillary bleeding and oozing by acting directly on the walls of the blood vessels. It decreases permeability.

This unique hemostat does not alter blood components, nor does it affect cardiac rate or volume. Useful both prophylactically and therapeutically, it is notable for a high index of therapeutic safety. Supplied in ampuls, tablets and as a syrup.

*Sherber, P.A. The control of bleeding, Am. J. Surg. 86:331 (Sept.) 1953.

Indicated in postoperative bleeding associated with:
Tonsillectomy, adenoidectomy and nasopharynx surgery
Prostatic and bladder surgery
Uterine bleeding
Postpartum hemorrhage
Dental surgery
Chest surgery and chronic pulmonary bleeding
Also: Idiopathic purpura
Retinal hemorrhage
Familial telangiectasia
Epistaxis
Hematuria

The unique systemic hemostat

Send for detailed literature

Adrenosem®

SALICYLATE

(BRAND OF CARBAZOCHROME SALICYLATE)

THE S. E. MASSENGILL COMPANY, Bristol, Tennessee

a convenient source of information useful to your staff

LEDERLE HOSPITAL EXHIBITS

this is a typical Lederle hospital exhibit

Lederle Hospital Exhibits help keep your staff well informed by providing them with information on products regularly used in hospitals. Residents, internes, nurses, students—all will find these exhibits to be interesting and worthwhile.

Furthermore, you can be completely assured that every exhibit will be arranged and conducted on the highest ethical plane. The Lederle Representative will be glad to schedule an exhibit for your hospital. See him for further information or write:

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Pearl River, New York

ILOTYCIN DROPS

(ERYTHROMYCIN, LILLY) ETHYL CARBONATE

with an unexcelled antibiotic spectrum

- Appeals to the physician for its effectiveness and safety
- Appeals to the nurse and mother for its convenience in administration
- Appeals to baby for its taste-tested flavor

another reason to

consider ILOTYCIN FIRST

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

hospitals

the journal of the American Hospital Association

volume 29 *number 3* *march 1955*

editor
Edwin L. Crosby, M.D.

executive editor
James E. Hague

managing editor
David T. Riddell

production manager
Newton J. Jacobson

assistant editors
Marianne Clarke
Barbara Elsholz
Marjorie M. Lawson
Charles S. McCaleb

advertising and business manager
Bremen I. Johnson

assistant advertising manager
Martha E. Miller

circulation supervisor
Dorothy Heller

TECHNICAL CONSULTANTS

housekeeping
Howard F. Cook

nursing
Marian L. Fox, R.N.

management
Ann Friend

accounting and finance
Ronald Jydstrup

education
Verne Kallejian

professional practice—medical review
Sarah H. Hardwicke, M.D.
Charles U. Letourneau, M.D.
Malcolm T. MacEachern, M.D.
Arnold A. Rivin

prepayment
Maurice J. Norby
James R. Neely

dietetics
Isola D. Robinson

insurance
William T. Robinson

hospital auxiliaries
Elizabeth M. Sanborn

laundry—purchasing
Joseph A. Williamson

literature
Helen Yast

hospital design, engineering—maintenance
Clifford Wolfe

legislation
Kenneth Williamson

ADVERTISING REPRESENTATIVES

Chicago: *Gordon A. Thoman*
18 E. Division St.—WHitehall 4-4350

New York: *George B. Janco*
369 Lexington Ave.—LExington 2-9940

Cleveland: *Eugene C. Leipman*
1220 Huron Road—SUperior 1-1373

Los Angeles: *Ren Averill*
234 E. Colorado St.—RYan 1-9291

Calendar of Association and Allied Meetings ... 6
Officers of the American Hospital Association ... 8
Index to Advertisers ... 198
Classified Advertising ... 199

articles

PLANNING

The Essential First Steps — E. Todd Wheeler ... 69
Meeting Changing Needs ... 72
- Rehabilitation Facilities — Howard A. Rusk, M.D. ... 73
- Nursing Homes — James P. Dixon, M.D. ... 74
- Diagnostic or Treatment Centers — John W. Cronin, M.D. ... 74
- Chronic Disease Hospitals — Marcus D. Kogel, M.D. ... 75
- Mental Hospitals — Charles K. Bush, M.D. ... 75

Facilities and Equipment for Isotopes Programs — G. W. Morgan ... 103
Design for Future Health Needs — Albert W. Snoke, M.D. ... 109
Planning for Maintenance — A. D. Barnes ... 116
Will the Equipment Meet the Need?
- The Dietitian's Criterion ... 130
- The Architect's Contribution — John W. Hargrave ... 131

More Linen at Half the Cost — Robert J. Dobson ... 144

BUILDING

A Medical Center Emerges from a Community Survey ... 76

EXPLORING

Six Ventures in Design
- Nursing Station ... 82
- Convalescent Unit ... 84
- Psychiatric Unit ... 86
- Central Distribution ... 88
- Rehabilitation Service ... 90
- General Hospital ... 92

EVALUATING

An After-the-Fact Study of a Hospital ... 94

LEARNING

Research in Function and Design — R. Llewelyn Davies ... 99

departments

Your President Reports ... 12
Opinions—Letters from Our Readers ... 18
Service from Headquarters ... 40
Editorial Notes ... 67
Medical Review ... 109
Engineering and Maintenance ... 116
Equipment and Supply Review ... 122
Dietetics Administration ... 130
The Literature ... 142
Laundry-Housekeeping ... 144
Personal News ... 150
News ... 157
Official Notes ... 157
Pro Re Nata — John H. Hayes ... 194

HOSPITALS is published the first of each month by the American Hospital Association, 18 E. Division Street, Chicago 10, Ill. Entered as second class matter January 9, 1936, at the postoffice at Chicago, Ill., under the Act of March 3, 1879.

SUBSCRIPTION RATES: To member hospitals and associated personnel, $2 a year; to others, $3 a year. Single copies, 30 cents, except two-part August issue, $1.50. (Foreign and Pan-American add $1.00 per year for postage)

COPYRIGHT: March 1955 by the American Hospital Association.

GEORGIA BAPTIST HOSPITAL, Edwin B. Peel, Administrator
Stevens and Wilkinson, Architects
Henry C. Beck Company, Contractor

SAFETY with an 18.7% annual return!

Effective protection against fire can be achieved with an automatic sprinkler system. Records of the National Fire Protection Association for a 10 year period reveal not one loss of life in 160 fires in hospitals having sprinklers. Contrast that with *unsprinklered* hospitals. Here, the record is shocking. Of 58 fires in *unsprinklered* hospitals, there were 226 deaths.

In an address before the 1954 session of the Southeastern Hospital Conference, the following statement was made by Mr. George E. Linney, Assistant Administrator, Georgia Baptist Hospital, Atlanta.

"Early in 1947 the Georgia Baptist Hospital installed a Grinnell Sprinkler System in its surgical building (now the west wing of the main building), also a similar system in a large nurses' residence. In 1952 the service building, including a warehouse, laundry, and repair shops, was protected by Grinnell Sprinklers. *The reduction in fire insurance was gratifying.*"

Mr. George E. Linney
Assistant Administrator
Georgia Baptist Hospital, Atlanta

For example (the figures are Mr. Linney's) . . .

Total Area Protected	Cost of Sprinkler Systems	Annual Savings in Insurance	System pays for itself in
108,000 sq. ft.	$27,792	$5,205.49*	5.34 years
*Represents 18.7% annual return on investment in Grinnell Sprinkler protection.			

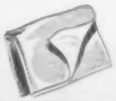
Mr. Linney adds . . . "Sprinkler installers cooperated to minimize disruption in daily routine. 'Business as usual' was carried on during the installation of the system."

Other hospitals, too, report on both the efficiency of Grinnell Sprinklers, and Grinnell installation crews. Why delay getting the complete facts? Grinnell will gladly outline a fire protection program for you, without obligation. Write Grinnell Company, Inc., 266 West Exchange Street, Providence, Rhode Island.

GRINNELL
PROTECTION AGAINST EVERY FIRE HAZARD

Manufacturing, Engineering and Installation of Automatic Sprinklers Since 1878

Koroseal Tubing


Koroseal Sheeting

Throat Collars

Hot Water Bottles

B.F.Goodrich

English type and Molded Ice Caps

Fountain and Combination Syringes

Boiled in steam but still "alive" plenty of strength and stretch

AFTER 15 twenty-minute sterilizations the glove shown above showed almost no loss in strength or stretch. In fact, careful lab procedure had to be followed in order to measure the difference at all. That's one proof that B. F. Goodrich surgeons' gloves outlast ordinary gloves—and therefore cost you less!

To save time in sorting, B. F. Goodrich gloves have sizes marked in colors. Colors won't wear off or fade. The numerals are extra large and easy to see even when the wrist is turned back and the glove is powdered. B. F. Goodrich gloves have long wrists and come in white or brown; smooth or "cutinized". Sizes 6-10.

"Special purpose" gloves for doctors who are allergic to ordinary rubber are just as thin as all other B. F. Goodrich gloves. They have red cuffs for easy identification. Sizes 6½ to 9½ are marked in color.

Examination gloves (short wrists) come in sizes 7 to 9. Order B. F. Goodrich surgeons' gloves from your surgical or hospital supply dealer or write: *The B. F. Goodrich Co., Sundries Sales Dept., Akron, Ohio.*

"MILLER" BRAND
Surgeons' Gloves
BY
B.F.Goodrich
INDUSTRIAL PRODUCTS DIVISION

hospital association meetings

AS SOON AS DETERMINED, NOTICE OF YOUR ANNUAL MEETING, AT WHICH OFFICERS ARE ELECTED, SHOULD BE MAILED TO DEPT. AH, 18 E. DIVISION, CHICAGO 10

AMERICAN HOSPITAL ASSOCIATION

Annual Convention of the American Hospital Association—September 19-22; Atlantic City (Traymore Hotel)

REGIONAL MEETINGS

(NEXT 12 MONTHS)

Association of Western Hospitals—April 25-28; San Francisco (Civic Auditorium).

Carolinas-Virginias Hospital Conference—April 21-22; Roanoke (Hotel Roanoke)

Maryland - D. C. - Delaware — Nov. 7-9; Washington, D. C. (Shoreham Hotel).

Middle Atlantic Hospital Assembly—May 25-27; Atlantic City (Convention Hall).

Mid-West Hospital Association—April 27-29; Kansas City (President)

New England Hospital Assembly—March 28-30; Boston (Hotel Statler).

Southeastern Hospital Conference—April 20-22; Atlanta (Atlanta-Biltmore).

Tri-State Hospital Assembly—May 2-5; Chicago (Palmer House).

Upper Midwest Hospital Conference—May 11-13; Minneapolis (Nicollet)

STATE MEETINGS

(NEXT SIX MONTHS)

Alaska—June 8-10; Fairbanks (Nordale Hotel).

Alberta—June 13; Banff (School of Fine Arts).

Arkansas—May 23-24; Little Rock (Marion Hotel).

Iowa—April 21; Des Moines (Savery Hotel).

Kentucky—April 12-14; Louisville (Seelbach Hotel).

Louisiana—April 28-29; Shreveport (Captain Shreve Hotel).

Maritime (Canada)—June 1955, St. Andrews, N. B. (Algonquin Hotel).

Massachusetts — May 25; Boston (Hotel Statler).

New Jersey—May 25-27; Atlantic City (Convention Hall).

New Mexico — Mar. 24-26; Albuquerque (Hilton Hotel).

New York—May 25-27; Atlantic City (Convention Hall).

North Dakota—April 26; Minot (Clarence Parker Hotel).

Ohio—March 7-10; Cincinnati (Netherland-Plaza Hotel).

Pennsylvania—May 25-27; Atlantic City (Convention Hall).

Tennessee—May 19-22; Chattanooga (Read House).

Texas—April 12-14; Houston (Shamrock Hotel).

Wisconsin—March 17; Milwaukee (Hotel Schroeder).

OTHER MEETINGS

(NEXT 12 MONTHS)

Canadian Hospital Association—May 9-11; Ottawa (Chateau Laurier)

Catholic Hospital Association—May 16-19; St. Louis (Kiel Auditorium)

AHA INSTITUTES

(NEXT 6 MONTHS)

Institute on Medical Record Library Personnel—March 21-25; Pittsburgh (Wm. Penn)

Institute on Nursing Service Administration —March 21-25; Buffalo, N.Y. (Statler)

Workshop on Supervisory Training—March 21-25; Boyes Springs, Calif. (Sonoma Mission Inn)

Institute on Operating Room Administration Services—April 18-21; Washington, D.C. (Sheraton-Park Hotel)

Engineering Institute and Workshop—April 18-22; Toronto (King Edward)

Institute on Operating Problems of Small Hospitals—April 25-26; Kansas City, Mo. (President)

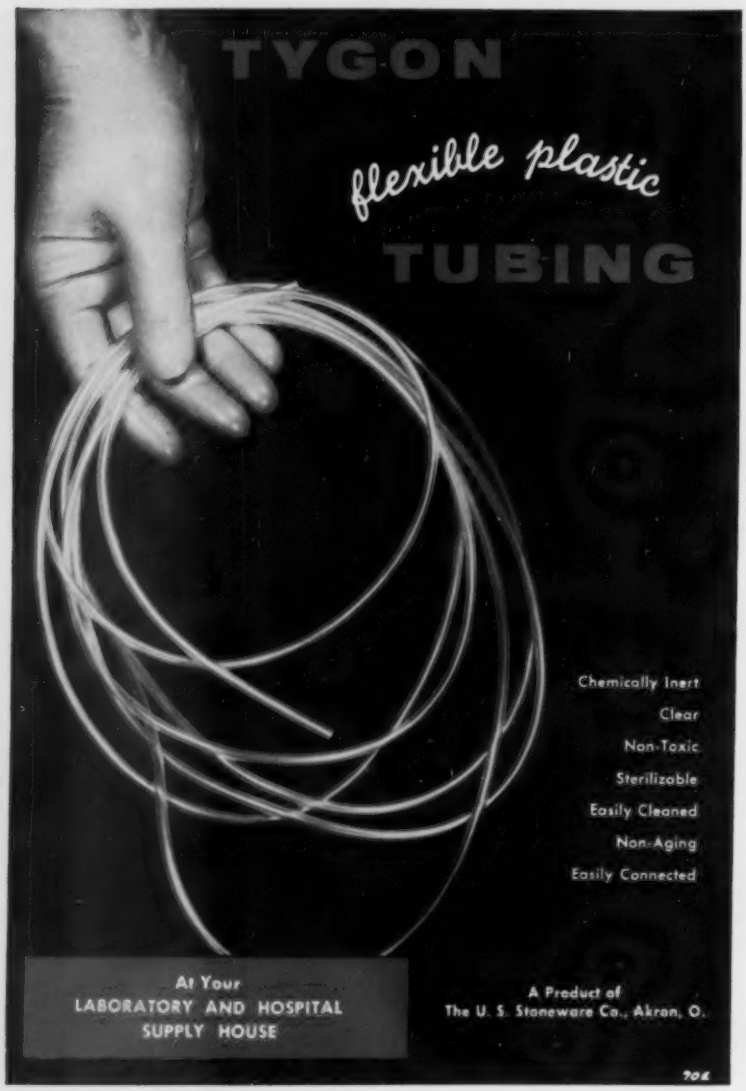
Institute on Dietary Department Administration—April 25-29, Boston (Somerset Hotel)

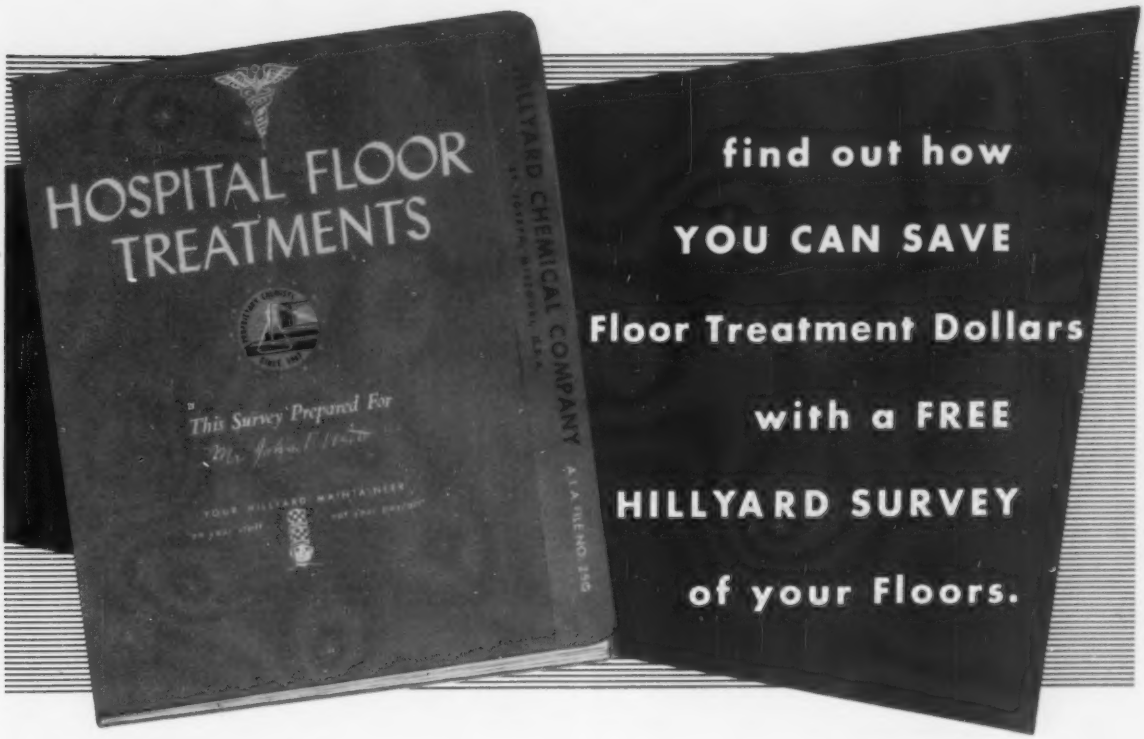
Institute on Occupational Therapy—April 25-29; Philadelphia (Drake)

Institute on Hospital Insurance—May 6-7; Chicago (Palmer House)

Institute on Hospital Law—May 9-10; Minneapolis (Nicollet)

(Continued on page 192)





A HILLYARD HOSPITAL FLOOR TREATMENT PLAN CAN SAVE MATERIAL AND LABOR COST

From Survey to Service you'll find Hillyard specialized floor treatments provide complete protection, beauty and economy—safe for your floors—safe for those who walk on them—have to last longer because they're made to answer particular hospital floor problems. They're famous for quality. The Hillyard "Maintaineer" near you is trained to efficiently and quickly make a *FREE* survey of your floors and sanitation problems and present a plan especially prepared for you. He will show you how your floors can be more beautiful—yet prove important savings in labor and materials.

All Specifications prepared in accordance with American Institute of Architects requirements.

***Write or Call Collect for the Name of your nearest* HILLYARD MAINTAINEER ®**

NO OBLIGATION . . .

on your staff, not your payroll

FLOOR HILLYARD TREATMENTS

ST. JOSEPH, MISSOURI

Branches and Warehouse Stocks in Principal Cities

SEND COUPON TODAY FOR FREE SURVEY

HILLYARD CHEMICAL CO.
St. Joseph, Missouri

Please have your Maintaineer call and make a free survey of my floors.

Name ..... Title .....

Institution .....

Address .....

City ..... State .....

officers OF THE AMERICAN HOSPITAL ASSOCIATION

PRESIDENT
Frank R. Bradley, M.D., Barnes Hospital, St. Louis 10

PRESIDENT-ELECT
Ray E. Brown, University of Chicago Clinics, Chicago 37

PAST PRESIDENT
Ritz E. Heerman, California Hospital, Los Angeles 15

TREASURER
John N. Hatfield, Passavant Memorial Hospital, Chicago 11

SECRETARY
Edwin L. Crosby, M.D. American Hospital Association, Chicago 10

Board of Trustees

Frank R. Bradley, M.D., *ex officio (chairman)*
Ray E. Brown, *ex officio*
H. M. Coon, M.D., University Hospitals, Madison 6
John N. Hatfield, *ex officio*
Ritz E. Heerman, *ex officio*
C. C. Hillman, M.D., Jackson Memorial Hospital, Miami 36
Robert S. Hudgens, Lynchburg General Hospital, Lynchburg, Va.
Jack Masur, M.D., assistant surgeon general, Public Health Service, Washington 25
William S. McNary, Michigan Hospital Service, Detroit 26
Mary C. Schabinger, R.N., DeEtte Harrison Detwiler Memorial Hospital, Wauseon, Ohio
Rt. Rev. Msgr. George Lewis Smith, director of Catholic hospitals, Diocese of Charleston, Aiken, S. C.
Tol Terrell, Shannon West Texas Memorial Hospital, San Angelo
J. Gilbert Turner, M.D., Royal Victoria Hospital, Montreal 2

Committee on Coordination of Activities

Ray E. Brown, *chairman*
Frank R. Bradley, M.D., *ex officio*
Madison B. Brown M.D., Hahnemann Medical College and Hospital, Philadelphia 2
Frank S. Groner, Baptist Memorial Hospital, Memphis 3
Stuart K. Hummel, Columbia Hospital, Milwaukee 11
Abraham Oseroff, Hospital Service Association of Pittsburgh, Pittsburgh 19
Oliver G. Pratt, Rhode Island Hospital, Providence 2
Albert W. Snoke, M.D., Grace-New Haven Hospital, New Haven 4
Mrs. Cecil D. Snyder, Kenosha Hospital, Kenosha, Wis.
Lucius R. Wilson, M.D., Episcopal Hospital, Philadelphia 25

Council on Administrative Practice

Oliver G. Pratt, *chairman*
Donald W. Cordes, *vice chairman*, Iowa Methodist Hospital, Des Moines 14
A. A. Alta, San Antonio Community Hospital, Upland, Calif.
James P. Dixon, M.D., Department of Public Health, Philadelphia 7
Richard R. Griffith, Delaware Hospital, Wilmington 1
Carl C. Lamley, Stormont—Vail Hospital, Topeka 1
Charles G. Roswell, MacNicol, Roswell & Co., New York 7
R. J. Stull, University of California Hospitals, San Francisco 22
Richard D. Vanderwarker, Memorial Center for Cancer and Allied Diseases, New York 21
Ann S. Friend, *secretary*, 18 E. Division St., Chicago 10

Council on Association Services

Stuart K. Hummel, *chairman*
J. Harold Johnston, *vice chairman*, New Jersey Hospital Association, Trenton 9
Hubert W. Hughes, General Rose Memorial Hospital, Denver 20
Mrs. Irene McCabe, Missouri Hospital Association, St. Louis 8
A. C. McGugan, M.D., University of Alberta Hospital, Edmonton
S. A. Ruskjer, Waverly Hills Tuberculosis Sanatorium, Waverly Hills, Ky.
W. W. Stadel, M.D., San Diego County General Hospital, San Diego 3
J. Stanley Turk, Ohio Valley General Hospital, Wheeling, W. Va.
Brig. Alvena H. Wood, R.N., William Booth Memorial Hospital, Covington, Ky.
Howard F. Cook, *secretary*, 18 E. Division St., Chicago 10

Council on Government Relations

Lucius R. Wilson, M.D., *chairman*
J. Douglas Colman, *vice chairman*, Johns Hopkins University and Johns Hopkins Hospital, Baltimore 5
Ted Bowen, Methodist Hospital, Houston 25
A. F. Branton, M.D., Baroness Erlanger Hospital, Chattanooga 3
Edison Dick, Passavant Memorial Hospital, Chicago 11
Hal G. Perrin, Bishop Clarkson Memorial Hospital, Omaha 5
Lester E. Richwagen, Mary Fletcher Hospital, Burlington, Vt.
Rt. Rev. Msgr. Charles A. Towell, Diocesan Director of Hospitals, Covington, Ky.
Clarence E. Wonnacott, Latter-Day Saints Hospital, Salt Lake City 3
Kenneth Williamson, *secretary*, Washington Service Bureau, Mills Building, 17th St. and Pennsylvania Ave., N.W., Washington 6

Council on Hospital Planning and Plant Operation

Frank S. Groner, *chairman*
Stanley A. Ferguson, *vice chairman*, University Hospitals, Cleveland 6
Sister Mary Antonella, St. Joseph Infirmary, Louisville 8
Clement C. Clay, M.D., Columbia University, New York 17
Brig. Gen. Elbert DeCoursey, MC, USA, Armed Forces Institute of Pathology, Washington 25
E. D. Rosenfeld, M.D., Long Island Jewish Hospital, New Hyde Park, L.I., N.Y.
Paul J. Spencer, Lowell General Hospital, Lowell
Ray E. Trussell, M.D., Hunterdon Medical Center, Flemington, N. J.
D. B. Wilson, M.D., University Hospital, Jackson 5, Miss.
Clifford Wolfe, *secretary*, 18 E. Division St., Chicago 10

Council on Prepayment Plans and Hospital Reimbursement

Madison B. Brown, M.D., *chairman*
R. K. Swanson, *vice chairman*, Swedish Hospital, Minneapolis 4
Very Rev. Msgr. Edmund J. Goebel, director of hospitals, Archdiocese of Milwaukee, Milwaukee 12
Ralph J. Hromadka, Santa Monica Hospital, Santa Monica
Harry J. Mohler, Missouri Pacific Hospital, St. Louis 4
James P. Richardson, Presbyterian Hospital, Charlotte 4
C. Rufus Rorem, Ph.D., Hospital Council of Philadelphia, Philadelphia 7
Clyde L. Sibley, Baptist Hospital, Birmingham 11
Edward K. Warren, Greenwich Hospital, Greenwich, Conn.
James R. Neely, *secretary*, 18 E. Division St., Chicago 10

Council on Professional Practice

Albert W. Snoke, M.D., *chairman*
Russell A. Nelson, M.D., *vice chairman*, Johns Hopkins Hospital, Baltimore 5
Rev. Hector L. Bertrand, S.J., Comité des Hôpitaux du Québec, Montreal 8
Lawrence J. Bradley, Genesee Hospital, Rochester 7
Robert R. Cadmus, M.D., North Carolina Memorial Hospital, Chapel Hill
T. Stewart Hamilton, M.D., Hartford Hospital, Hartford 15
Frederick T. Hill, M.D., Thayer Hospital, Waterville, Maine
Karl S. Klicka, M.D., Presbyterian Hospital, Chicago 12
Sister M. Michael, R.N., Misericordia Hospital, Philadelphia 43
Charles U. Letourneau, M.D., *secretary*, 18 E. Division St., Chicago 10

Committee on Hospital Auxiliaries

Mrs. Cecil D. Snyder, *chairman*
Mrs. Edmund H. Smith, *vice chairman*, Seattle General Hospital, Seattle 4
Mrs. Fred C. Baldwin, University Hospitals of Cleveland, Cleveland 6
Mrs. Frederick N. Blodgett, New England Medical Center, Boston 11
Mrs. John D. Brockway, Hospital of the Good Shepherd, Syracuse 10
Mrs. George C. Capen, Hartford Hospital, Hartford 15
Mrs. James Enyart, Iowa Methodist Hospital—Raymond Blank Memorial Hospital for Children, Des Moines 14
Mrs. Norman J. Kauffmann, Touro Infirmary, New Orleans 15
Mrs. A. C. Rood, Presbyterian Hospital Center, Albuquerque
Mrs. Arthur B. Slack, St. Luke's Hospital, Denver 10
Mrs. Alfred H. Taylor, Evanston Hospital, Evanston, Ill.
One vacancy
Elizabeth M. Sanborn, *secretary*, 18 E. Division St., Chicago 10

Blue Cross Commission

Abraham Oseroff, *chairman*
Robert T. Evans, *vice chairman*, Blue Cross Plan for Hospital Care, Chicago 90
Carl M. Metzger, *treasurer*, Hospital Service Corporation of Western New York, Buffalo 2
Kenneth B. Babcock, M.D., Joint Commission on Accreditation of Hospitals, Chicago 11
Rt. Rev. Msgr. John W. Barrett, director of Catholic hospitals, Archdiocese of Chicago, Chicago 5
Arthur M. Calvin, Minnesota Hospital Service Association, St. Paul 4
Frank F. Dickson, Northwest Hospital Service, Portland 7
Charles Garside, Associated Hospital Service of New York, New York 16
Roger W. Hardy, Massachusetts Hospital Service, Boston 6
John R. Hill, Tennessee Hospital Service Association, Chattanooga 2
Basil C. MacLean, M.D., Commissioner of Hospitals, New York City Department of Hospitals, New York 13
Elmer F. Nester, Group Hospital Service, St. Louis 8
James E. Stuart, Hospital Care Corporation, Cincinnati 6
D. Lane Tynes, Blue Cross Hospital Plan, Louisville 2
Ruth Cook Wilson, Maritime Hospital Service Association, Moncton, N. B.
Richard M. Jones, *director*, 425 N. Michigan Ave., Chicago 11

Executive Staff

Edwin L. Crosby, M.D., *director*
Maurice J. Norby, *deputy director*
Kenneth Williamson, *associate director*
Charles U. Letourneau, M.D., *assistant director*
Malcolm T. MacEachern, M.D., *director of professional relations*

New!

BOLTA PRESENTS

A NEW WATER CARAFE

in decorator colors . . .

with its own cup

that fits like a stopper

There's never been a bed-side carafe so practical and functional: It keeps its own cup at hand! Withstands temperatures up to 180° F. It's engineered to wash in commercial dishwashers! It keeps cold! It's easy to fill! It's stain and acid resistant!

There's never been a bed-side carafe so colorful and beautiful: It comes in exhilarating shades of Coral, Turquoise, Bottle Green, Grey, Chartreuse. And the lines are so modern, smart and attractive, it makes pure cold water taste better than you ever thought possible!

PACKED ONE DOZEN PER COLOR TO A CARTON

Bolta

PRODUCTS
Lawrence, Mass.
A Division of The General Tire and Rubber Co.

Planning to Re-decorate? Specify BOLTAFLEX *for booths and furniture,* BOLTA-WALL *for interiors*

In the main kitchen, Citrus Yellow Suntile combines sparkling cleanliness and high light reflection for better vision in interior areas.

You can make the building part of the cure with FUNCTIONAL COLOR *Suntile*

The handsome new Jackson Memorial Hospital in Miami, Florida, shows how a single versatile material—real clay Suntile—serves as a multi-purpose finish in any hospital area.

"We have been very happy with the results," says Dr. C. C. Hillman, Executive Director.

Wainscoting of Light Jade Green Suntile brightens this clean-up room, also promotes sanitation.

Jackson Memorial Hospital, Miami, Fla., Steward & Skinner, Architects.

In operating rooms, Sea Green Suntile provides a neutralized color which reduces eye fatigue, and helps surgeons' vision by supplying a restful complement to colors of tissue.

In scrub-up rooms, kitchens and operating rooms, Suntile is used as an important aid to sanitation. Its glazed, impervious surface set in tight, thin mortar joints discourages bacterial growth, permits thorough cleaning with minimum time and effort.

Architects Steward & Skinner also make skillful use of Suntile's functional colors—which are scientifically planned to fit hospital needs by Faber Birren, nationally known color authority.

In patient areas, light, cheerful Suntile colors can have a tonic effect. Where exacting visual tasks are performed, more neutral shades help vision and reduce fatigue.

And wherever it is used, Suntile provides the other lifetime benefits of quality clay tile —permanence, freedom from refinishing, fire-safety, substantial maintenance savings.

To learn how Suntile can help your hospital serve patients and staff better, write for free copy of our booklet, "Suntile Color Recommendations." Address Dept. H-3.

THE CAMBRIDGE TILE MFG. CO.
P. O. Box 71, Cincinnati 15, Ohio

WEST COAST OFFICES

The Cambridge Tile Mfg. Co.
470 Alabama Street
San Francisco 10, California

The Cambridge Tile Mfg. Co.
1335 S. LaBrea
Los Angeles 19, California

your president reports

WE WERE INVITED to talk to the Hospital Council of Southern Florida during January and we attempted to outline what we mean by thoughtful administration. We present here what we believe are some fundamental concepts.

The first step in thoughtful administration is to use previous knowledge and experience to delimit what we mean by thoughtful administration. Another way of putting it is this—we want to exclude from our thinking all but the relevant factors. The more we can exclude, the better.

The second step is to do controlled quantitative and qualitative experiments on and with these few relevant factors. The third step is the most difficult of all and is also the most difficult to describe. We can try to put the results of our experiments in the second step in table form, a graph, or an equation so that they will fall into a general law, or if this is not possible, then we can try some hypothesis (often called theory), or generalization based on our experiments. This hypothesis or theory must then be checked and tested by new experiments.

Let us see if we can state some relevant factors which our previous knowledge and experience indicate needs thought by the administrator. First, and foremost, is the definition of a hospital. What is a hospital? That question has not been satisfactorily answered. We have described it as a loosely integrated institution quite complex in nature.

Having a definition is one relevant factor. Let us delimit another. What is the function of a hospital? Functionally, the acute general hospital is for the care of the sick and injured with diagnostic facilities necessary thereto. With these two factors, a generalized definition and function, we can begin to delimit and discuss other factors. One is the attitude of the patient toward the hospital—one of the most important problems of public relations which confronts us. How can we gauge it? How can we influence it?

What do people usually criticize about hospitals? Our experience is that they criticize mostly things which they can control in their daily lives, homes, apartments, hotels and restaurants—things like food, beverages, sights, smell and noise.

If people like the taste, flavor and odor of a certain food, cooked and seasoned in a certain way, they seldom change. Most good chefs and food caterers know this and they try to prepare the dish in the same way each time. We all are familiar with the care which good coffee is blended because if we like a certain blend, that is what we want. The same is true of tobaccos, beverages and spices.

What do people not criticize? We believe mostly things they cannot control in their daily lives; good medical, surgical and obstetrical care. Of course, part of their lack of criticism of those services is because they are not informed enough to criticize.

We do not suddenly sprout new personalities. The characteristics with which we are born and which we have developed ever since babyhood are still intense. We may momentarily inhibit some of our characteristics but not for long. We still want a hospital to be like a home. Can it? Hospitals are not homes, hotels, cinemas, soda fountains or concert halls and are not to be judged by the amount of entertainment provided. They are places for the cure of the sick and injured. If we are unable to do that, then hospitals are next a place of sanctuary and of service

STERILIZATION TODAY but *NOT* TOMORROW

Learn how to wrap your dressings loosely, how to pack them into the autoclave chamber properly and to watch all the gauges and instruments during the sterilization. It will give you sterile dressings today.

But tomorrow—someone else runs the autoclave. Will she be as careful as you are? . . . Diack Controls are for people who know that sterilization is only as perfect as the person who runs the autoclave—that Diack Controls check that slip-up which is bound to occur; if not today—then tomorrow.

SMITH & UNDERWOOD

ROYAL OAK, MICHIGAN

Sole Manufacturers of Diack Controls and Inform Controls

always your best buy

standard for initial control of failure

MERCUHYDRIN® sodium

(BRAND OF MERALLURIDE INJECTION)

"...more advantages in the treatment of congestive heart failure than any of the other mercurial diuretics for parenteral use"[1]

and for maintenance **NEOHYDRIN®**

(BRAND OF CHLORMERODRIN)

replaces injections in 80 to 90% of patients[2,3]

references

1. Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams & Wilkins Company, 1954, p. 1006.
2. Leff, W., and Nussbaum, H. E.: J. M. Soc. New Jersey 50:149, 1953.
3. Moyer, J. H.; Handley, C. A., and Wilford, I.: Am. Heart J. 44:608, 1952.

Leadership in diuretic research

Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

82158

rendered without distinction of color, creed or money.

We are not surprised that the greater number of people want hospitals to be like homes. What shall we do? In our opinion it is natural for people to want a hospital to be like their home and we must be sympathetic and understanding and try to make the hospital as comfortable for them as possible, consistent with good medical care and sound economics. After we have done that, we believe that we should not be too seriously disturbed by criticism from this angle.

What relevant factors should we select for quantitative and qualitative research? Let us look. The increasing recognition of hospitals is causing a great deal of intellectual curiosity about them, and has attracted an increasing number of persons to the study of hospital administration. We have sociologists and anthropologists studying us. Universities are interested in the possibility of opening schools of hospital administration. The clamor over financing of medical and hospital care, the issue of socialized versus voluntary medicine, of corporate practice by hospitals, miracle drugs, etc., has stimulated an interest wider than many of us realize. With this interest come many questions, some we hospital administrators cannot answer, at least lucidly. Here are research problems for us.

Let us discuss one, the financing of hospital and medical care. We have been doing quantitative and qualitative experiments with all types of financing hospital care, not only in actual practice in the operation of group insurance of all types, but through at least two commissions, recently through the Commission on Financing of Hospital Care which was sponsored by the American Hospital Association. The results are just being published and merit your careful study. Great care must be taken that the conclusions reached should be about relevant factors and on the basis of a broad general concept of the hospital and not on the basis of any one segment.

The segments of hospital function or financing are all a part of our definition of a hospital and its function. They are, however, more susceptible of definition in that we have, because of convenience in operating and studying hospital function, subdivided the hospital into departments and sub-departments, functions and sub-functions, as medicine is subdivided into specialties and sub-specialties. The difficulty with this fragmentation for purpose of study or function is that one may come to an erroneous conclusion or carry out a wrong function on the basis of considering only one segment of the hospital.

When we try to tabulate the results of our experiments, we are immediately involved with the basic fact that human service has two components, the tangible and spiritual. It has been said that the reason that the social sciences have made such little progress with experimental research is because of the intangible factors which cannot always be reduced to figures, graphs and linear terms.

We believe that the handicap does not exist, or at least is less, when we are giving real service to real people. Then both the tangible and spiritual results can be evaluated. When an act, a real service, is done, there are tangible, visible, feasible, touchable, provable and conceivable results which can be appraised, seen, felt, heard and deducted both by direct and indirect or parallel methods.

An act is a tangible factor. Where we have difficulty sometimes is in seeing results of that act of service. Usually we can see the results of medical treatment and hospital service, by the effect on the patient's disease or injury or by his reaction toward us who serve him. What may cause more difficulty is the value that we place on the so-called individual service. The spiritual value, and we like to say spiritual reality, is whether we consider the service to be good or bad.

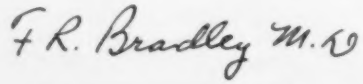
Whether or not the description of good and bad is the right one, or whether we know which is good and which is bad, the realities of actions on our part when we give service are evident realities. Whether a man kills another man in self-defense or in cold blood may never be settled to anybody's satisfaction including the killer's; but the death which the killer's act brought about is a reality, and it has a spiritual value.

We cannot be logical without assessing and giving spiritual value to our actions, otherwise we would be simply passionate and illogical savages. We assess moral and spiritual values in order to control our actions. Our laws are used for relief of oppression, a protection of the user and an attempt to dignify the individual and to do universal good. Standards for the control of the quality of medical and hospital care are tangible and spiritual realities. To maintain them is difficult, because they include positive action on our part!

If there is one relevant factor about which we must be thoughtful, it is that of leadership. There are two ways of leading people; one by organization and manipulation; the other intellectually—by argument, by demonstration of principles and by clear exposition of ascertained facts. Both are necessary, but the latter is more desirable.

Never has there been a time when administrators stand more in need of the power of clear statement readily understood by their boards, by their employees and by the public, an audience with no technical, medical knowledge and, except for the professional personnel, little or no understanding of the aims, ideals and tradition of professional service.

To do this, the administrator must be able to express himself in a way that can be understood and with a force that carries conviction. To do so he must be in contact with the current of human thought. He must, himself, be interested in things outside the limits of his own profession and must have at his command as large a part as possible of the aspirations, the attainments, the traditions and the accumulated wisdom of our country. This is what is called general culture. Other things being equal, the more the administrator has of it, the more persuasive and telling his influence will be.



F. R. Bradley, M.D., president
American Hospital Association

Roto-Matic for sleeves, yokes, collars, pant toppings, small pieces, etc.
Roto-Matic for large parts of uniforms, pant legs, coat bodies, etc.

Greatest single advancement in production and quality finishing!

THE UNIPRESS ROTO-MATIC

ONE OPERATOR WITH LESS EFFORT ACTUALLY DOUBLES HOURLY OUTPUT OF NURSES UNIFORMS AND COATS, PANTS, APRONS AND OTHER ARTICLES.

The Unipress Roto-Matic, a brilliantly engineered, single-operator finishing unit, virtually antiquates stationary presses with its unsurpassed quality and production performance.

Operating on a compact turntable mounted with multiple presses, sleek, highly polished chrome heads open and close in synchronized action as the operator effortlessly makes the lays on the continually revolving presses. Timing can be adjusted for training.

The unusually high production of 25 or more nurses' uniforms and similar articles per hour per operator produce twice as much per hour per operator than ordinary stationary presses, while maintaining high quality standards is a result of the unique, pace-setting principle of the Unipress Roto-Matic. The production rate is automatically set by the unit itself and operator labor is reduced to making of lays only.

Labor shortages and high costs are minimized when you plan with Unipress Roto-Matics... Operators find them untiring and twice normal production rates reduce costs per article in half.

Be Sure to See Unipress Roto-Matics . . . They Pay for Themselves *Out of Direct Savings!*

THERE'S A LOCAL UNIPRESS DISTRIBUTOR TO SERVE YOU!

finer finishing faster with

UNIPRESS

THE UNIPRESS COMPANY
2800 LYNDALE AVENUE SOUTH MINNEAPOLIS, MINN.

THE UNIPRESS COMPANY
2810-B Lyndale Ave., South, Minneapolis, Minn.

Please send information and literature on the UNIPRESS ROTO-MATICS.

Name of Hospital_____

Individual_____

Address_____

City_____ Zone_____ State_____

Another hospital laundry
modernized by AMERICAN!

Boston Lying-In Hospital

cuts laundry operating costs $12,000.00 a year!

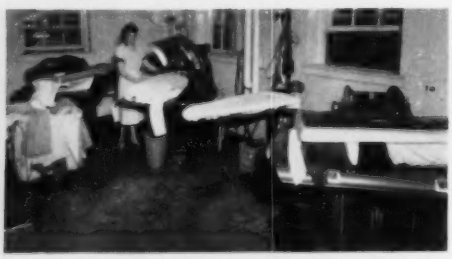
225-bed Boston Lying-In Hospital, Boston, Mass., reduces laundry costs $12,000.00 a year by modernizing with American. Shown here, three easy-to-operate American Cascade Washers and a Monex O. T. Extractor.

Ups production 50% with 3 less employees!

That's what happened when Boston Lying-In Hospital modernized with American laundry equipment. Their problem? A big increase in clean linen requirements. Antiquated equipment couldn't satisfy this need *without* payment of excessive overtime. Their solution? A completely modern American-equipped laundry which produces highest-possible quality work—faster! Their savings? $12,000.00 annually in laundry operating costs! A production increase of 50%! The release of three laundry employees for other duties!

Whether your laundry volume is large or small, it will pay to call in your American Laundry Consultant. His visit and recommendations are made without cost or obligation to you. Call him in soon.

Partially responsible for tremendous production increase of 50% is this Streamline Ironer with Airvent Canopy.



Two air-driven Super-Zarmo Presses and a Super-Zarmoette Press give perfection finish to staff and student uniforms.

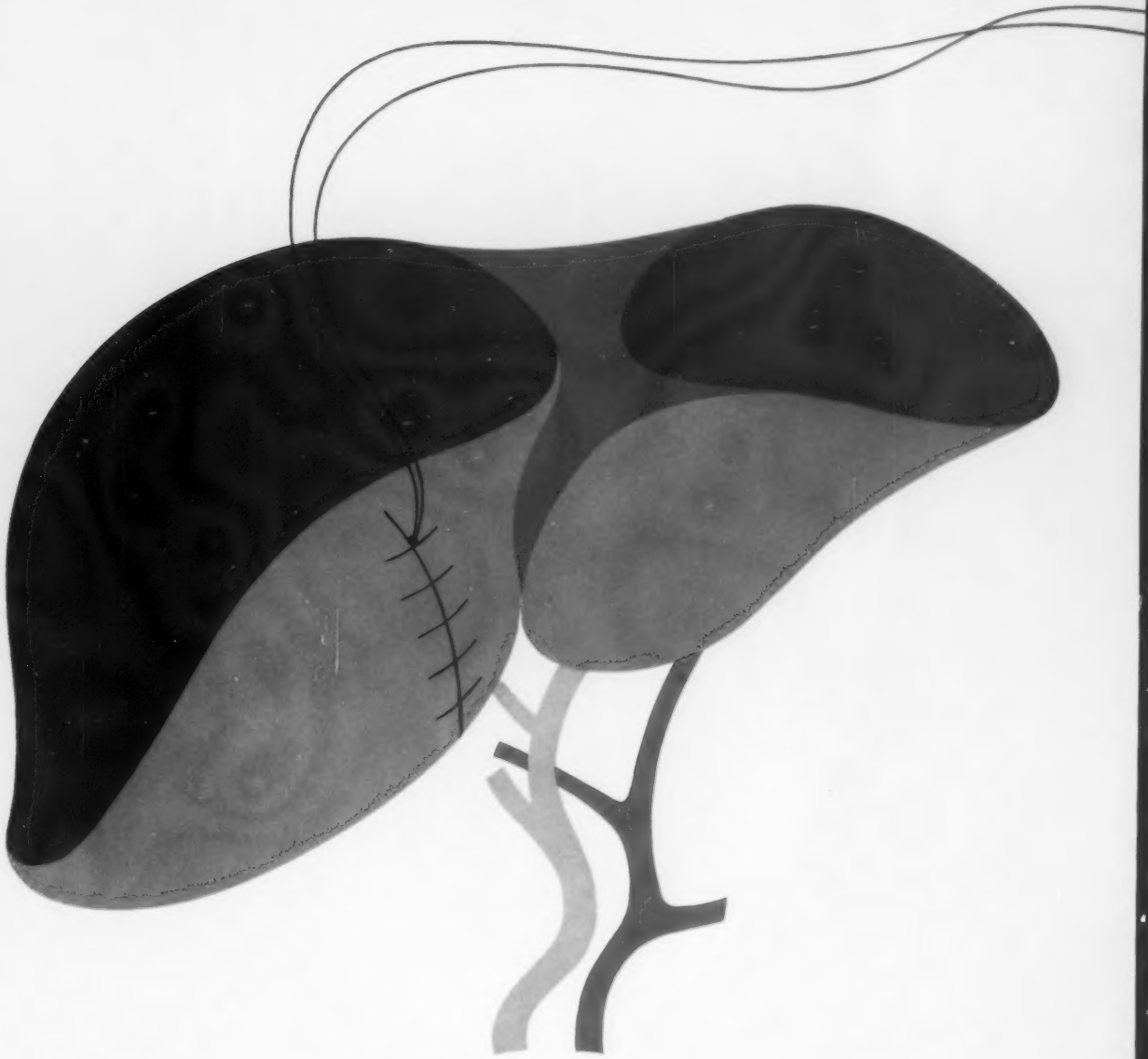
You can depend on your American Laundry Consultant's advice in your selection of equipment from the *complete American line*. Backed by our 87 years' experience in planning and equipping laundries, he can help solve your clean linen problems. Ask for his specialized assistance anytime . . . no obligation.

American

The American Laundry Machinery Company, Cincinnati 12, Ohio

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment

2800 LYNDALE AVENUE SOUTH MINNEAPOLIS, MINN.



setting new standards

ETHICON®

sutures

reverse cutting

ATRALOC NEEDLE SUTURES

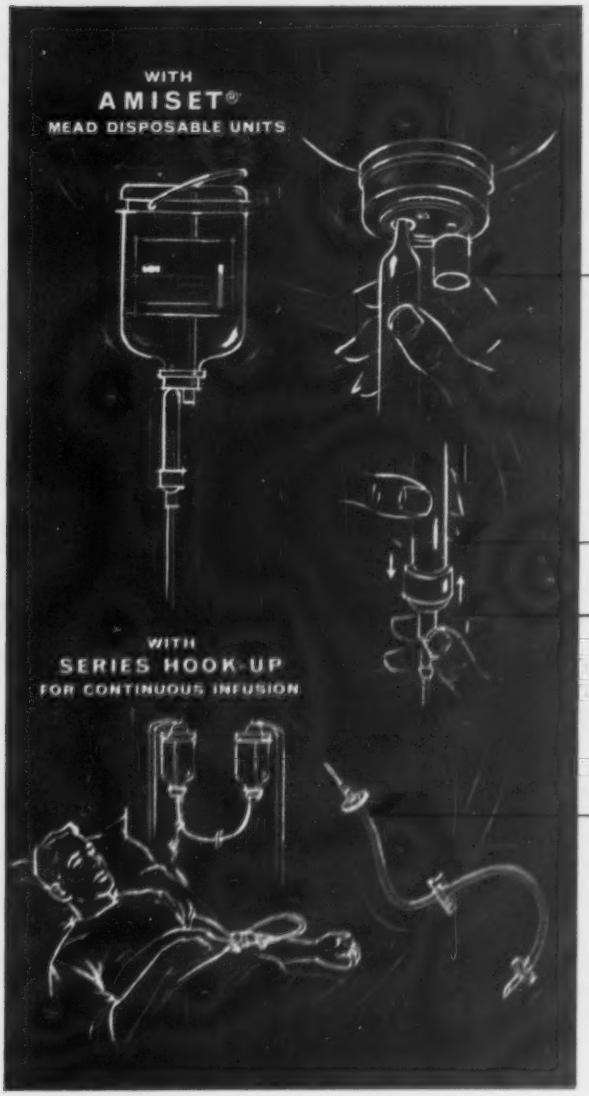
20% more needle strength

ETHICON

EXCLUSIVE WITH MEAD...

"the constantly closed system"

FOR PARENTERAL INFUSION



... versatile
... convenient
... always safe

Mead's exclusive infusion system, constantly closed to room air, provides maximal control of asepsis at all times. The Mead filter* at the air inlet sterilizes all incoming air, when vacuum is released, and *throughout infusion.*

One-piece, solid rubber stopper, together with vacuum packing, doubly assures sterile, stable, non-pyrogenic solutions.

*U. S. patent 2,568,108

Shatter-proof dripmeter—easy to hold and easy to insert.

Flexible rubber pump connects dripmeter and tubing, permits instant filling of dripmeter, and avoids troublesome air bubbles in tubing.

The Mead Series Hook-Up Unit permits instant attachment of additional infusion flasks. In prolonged infusions asepsis is assured by the Mead air-filter. Incoming air is *always filtered.*

These exclusive features, along with many others, represent Mead's constant and intensive effort to provide the ultimate in refinement for patient protection and convenience in use.

TAKE ADVANTAGE OF MEAD'S COMPLETE PARENTERAL LINE

Amigen (protein) Solutions	Levugen (fructose) Solutions	Dextrose Solutions	Special Electrolyte Solutions	Standard Electrolyte Solutions	Parenteral Solution Equipment	Blood Flasks and Equipment

AVAILABLE TO YOUR HOSPITAL FROM CONVENIENTLY LOCATED MEAD WAREHOUSES

Parenteral Products Division | MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A. MEAD

Trend in Christmas giving diverts gifts from hospitals

TO THE EDITOR
Dear Sir:

I HAVE RECENTLY seen several letters sent to customers by business organizations stating that they were discontinuing the practice of giving Christmas gifts to individuals connected with firms buying or using their services and instead were making substantial contributions to worthwhile organizations. I think this is a healthy trend and diverts the money formerly used to purchase gifts to charities of general interest.

One of the letters I received was from a concern in the hospital supply business and its donation had been sent to the National Foundation For Infantile Paralysis.

I am the first to acknowledge the importance of polio, heart and other organizations; but it seems ironical that the gifts diverted away from individual hospitals should go to projects outside of the hospital field.

I am wondering if the American Hospital Association could not ethically set up some kind of fund or project into which sums could be paid that would be attractive to givers of this type. Certainly many firms doing business almost exclusively with hospitals would be likely to respond to such a measure.—DOROTHY PELLENZ, *superintendent, Crouse-Irving Hospital, Syracuse, N. Y.*

Thanks for auxiliary tribute

TO THE EDITOR
Dear Sir:

IT WAS A MOST pleasant experience to happen on that nice tribute to hospital auxiliaries in the editorial notes in HOSPITALS. Many an auxiliary president across the country will take a deep breath and work harder for those encouraging words.

It is a slow process to develop an auxiliary program, but, after a group once gets organized, I am constantly amazed at the splendid accomplishments it makes.

There is a very precious and intrinsic value to me in the work of a volunteer in relation to that of a professional. Of course we need the professional worker to perform all of the technical duties of patient care—but the volunteer, if properly directed, can contribute that intangible something not possible otherwise.—MRS. CECIL D. SNYDER, *chairman, Committee on Hospital Auxiliaries, American Hospital Association.*

Correction in February article

TO THE EDITOR
Dear Sir:

I WANT TO THANK you for publishing my article entitled "The Tissue Committee, A Key to Efficiency" in the February issue of HOSPITALS (p. 81). It is flattering to me to know that you consider my article to be of sufficient quality to be worthy of publication in your magazine.

I would like to call your attention to a variation from my original article to that published. The sentence "second, the surgeon must record his pre-operative diagnosis (4) immediately following surgery." appears in print. I quote as follows regarding the same sentence from the original paper I submitted, "second, the surgeon must record his preoperative diagnosis (4) immediately prior to surgery and the postoperative diagnosis (5) immediately following surgery. It is obvious there is a great variation in meaning and interpretation in the comparison.

In regard to such an elementary thing as recording the preoperative diagnosis, I feel it is particularly unfortunate to me that an article should appear under my name stating that the preoperative diagnosis is obtained after surgery. I feel sure that the Medical Staff of the Carmi Township Hospital will be upset as well. If it is possible, I would like to have this error corrected in your next issue. —PAUL X. ELBOW, *assistant administrator, Borgess Hospital, Kalamazoo, Mich.*

(Editor's Note. The editors of HOSPITALS regret the unintentional omission of the phrase referred to by Mr. Elbow.)

Letters from readers are welcome. They should be brief and must be signed. HOSPITALS reserves the right to edit letters for space reasons. Address letters to the Editor, HOSPITALS, the Journal of the American Hospital Association, 18 E. Division Street, Chicago 10, Illinois.

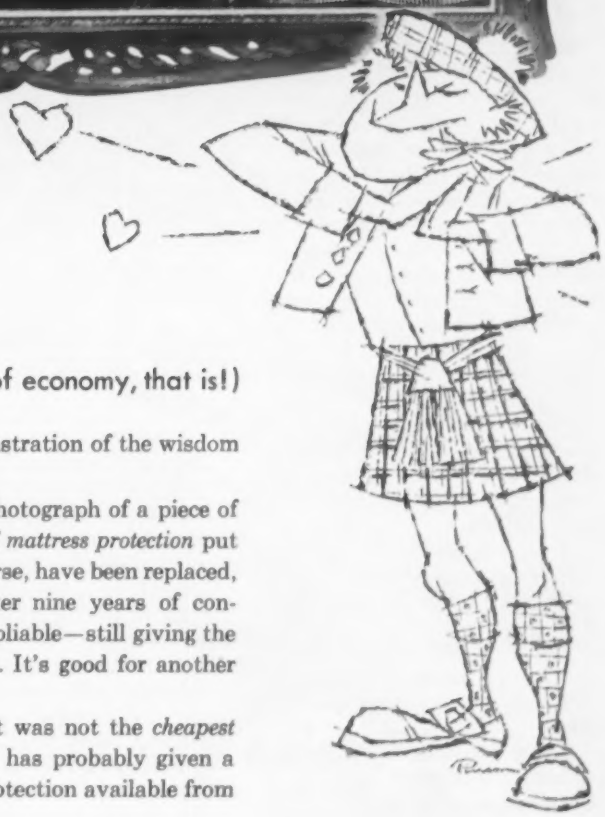
Legal topics merit discussion at hospital group meetings

TO THE EDITOR
Dear Sir:

THE SMOOTH AND EFFICIENT manner in which an institute or an assembly is conducted aften belies the many long and anxious weeks of planning, preparing and arranging that precede such an event. It was with a great deal of personal interest that I read the splendid article regarding the New England Hospital Assembly that appeared in the January issue of HOSPITALS.

Last year, I had my first opportunity to attend the New England Hospital Assembly. I was present in the capacity of legal counsel to several hospitals in Rhode Island. The speakers were most proficient and well qualified. The program had a fine balance and covered a good cross section of the many administrative problems that are incident to the operation of every general hospital. All in all, my first attendance at an assembly of New England hospitals was a memorable occasion for me.

As I indicated in a recent communication to the Program Committee of the Assembly, I hope that in future planning some session of the Assembly will be devoted to a discussion of hospitals and the law. As a lawyer, I am keenly aware of the legal problems ac-



un-beautiful
un-romantic
but it's a

MASTERPIECE! (of economy, that is!)

If there was ever a demonstration of the wisdom of buying QUALITY, here it is.

The above unretouched photograph of a piece of **Tomac Rubber Sheeting** shows a unit of *mattress protection* put in use in 1946! The muslin ends, of course, have been replaced, time after time. But the sheeting, after nine years of continuous use and abuse, is still soft and pliable—still giving the protection for which it was purchased. It's good for another couple of years.

When it was purchased it was not the *cheapest* but it was the *best*. Over the years, it has probably given a hospital the *least expensive* mattress protection available from any source or by any means.

Suppliers of the best—for the world's best hospitals

American Hospital Supply *corporation*

GENERAL OFFICES • EVANSTON, ILLINOIS

hospital administrators throughout the country. The American Hospital Association recently took the lead and set the pattern in this matter by conducting an Institute on Hospital Law which I had the good fortune of attending in Chicago.

Regional assemblies should likewise make provisions to acquaint their members with the developments in the law as it affects them and with the trends in the law in other areas of the country as these trends affect the hospitals, administrators, medical staff and nursing service.—WILLIAM A. REGAN, *legal counsel, Rhode Island Hospital, Providence, R. I.*

National Hospital Week benefits pointed out

TO THE EDITOR
Dear Sir:

NATIONAL HOSPITAL WEEK offers a rallying point for getting the hospital story before the public and before the hospital personnel.

True, many of the hospitals offer annual reports at the beginning of the year, but too many of them are lost in the welter of information coming from various corporations, governmental agencies and others bent on getting the public's ear.

The week in May gives hospitals a clearer field in which to tell its general story to the community, to hold special informative meetings for its own personnel and to get its fair share of attention from the several media of information such as the daily press, radio, television and magazines.

It offers a wonderful opportunity to stage special events at which the hospital may honor veteran employees.

The week may be used as a climax for a suggestion contest or an employee-of-the-year presentation.

Truly, National Hospital Week benefits are limited only by the imagination and ingenuity of people in hospital administration.—SISTER CARLOS, R.N., *administrator, Hotel Dieu, New Orleans, La.*

Inquiries stimulated by article

TO THE EDITOR
Dear Sir:

I HAVE RECEIVED THREE letters requesting information on our program for training technicians for the operating room. These and a fourth inquiry were stimulated by publication of my and Miss Schehl's article in the January issue of HOSPITALS.

Quoting from one of the letters:

"We would like to start such a program in our hospital which is listed as a general 76-bed institution. We would appreciate it if you could send us some material on the job qualifications of the operating room technicians and any additions to the curriculum as described in your article.

"Even though we are not a teaching institution, your splendid presentation of your program inspires us to try such a plan in our hospital."

The inquiry previously mentioned resulted in a conference to discuss with the director of nursing and operating room supervisor of another hospital their starting a program.

We are quite pleased with this good response.—FLORENCE M. ALEXANDER, *formerly assistant director of nursing, Syracuse (N.Y.) Memorial Hospital, is now a full time student at Syracuse University, completing work for an MS in nursing education.*

Checking flowmeters

TO THE EDITOR
Dear Sir:

I READ THE ARTICLE in the August issue of HOSPITALS describing retrolental fibroplasia with a great deal of interest. Shortly after publication of the article, Monadnock Community Hospital received a letter from a commercial concern, from which I quote the following paragraphs:

"It is now apparent . . . that (incubators) will be used increasingly for the majority of prematures without added oxygen. When oxygen is indicated and prescribed, maintenance of stable concentrations below 40% will be of paramount importance.

". . . Now that the vital need of insuring constant levels below 40% has become so clearly apparent, we are making one definite recommendation and one suggestion:

"RECOMMENDATION—Removal of the small float in the air-oxygen intake assembly. This will increase the total amount of air and oxygen that is introduced into the air-conditioning system, thereby minimizing the effect of external factors which might inadvertently cause changes in concentrations within the (incubator).

"SUGGESTION—Use an accurate, low-range flowmeter."

It will be evident that the accuracy of the flowmeter is of major importance. It will also be evident that the individual responsible for such accuracy must have some sure-fire method of checking flowmeters to re-assure himself as to the safety of their continued use.

Some years ago, I developed an accurate method for testing flowmeters. Briefly, it is the water displacement method.

The equipment required is a large pan or tub, deep enough to hold a small wooden platform through which a gallon glass jug can be inverted. The tub or pan is filled with water to a depth sufficient to cover the mouth of the jug when it is inverted. The jug is filled with water, capped, and inverted with the mouth under water. The cap is then removed, and a tube leading from the flowmeter is inserted in the mouth of the jug for several inches.

Flow, at a predetermined literage, already has been established, and all that is now required is to open the tank valve.

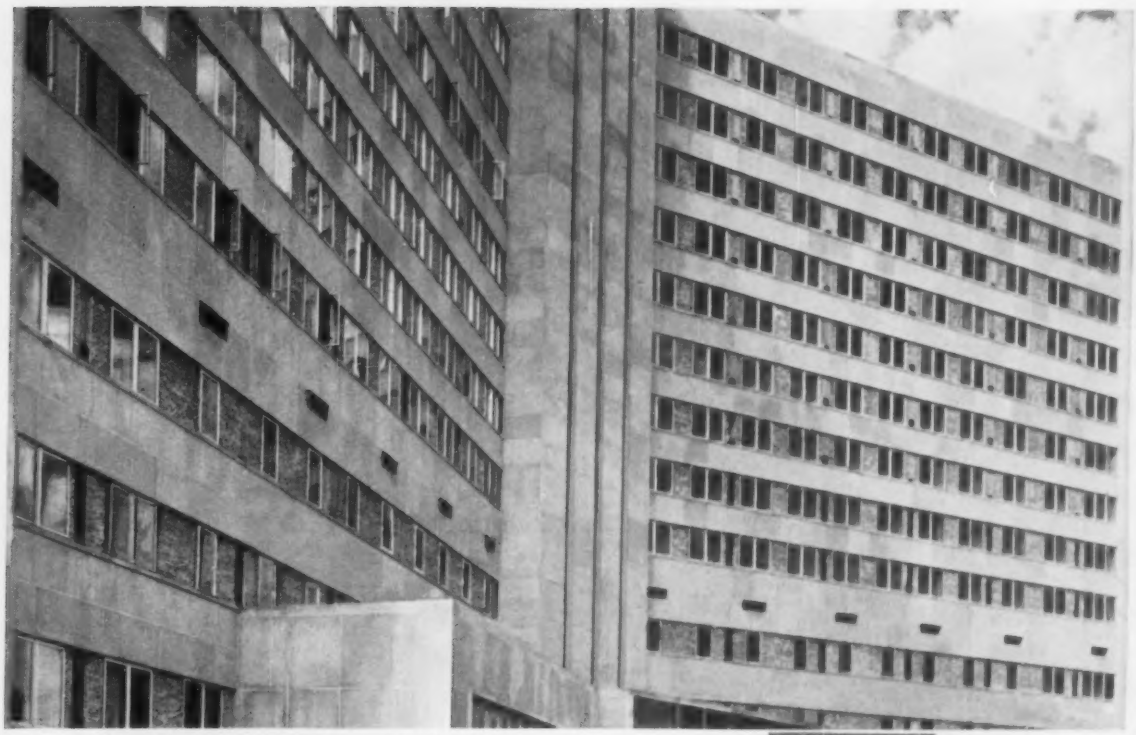
As oxygen flows from the tube into the jug, water will be displaced and will run out into the tub. The table I use for checking —worked out by experiment—is as follows:

To displace one gallon at a flow of 12 liters per minute (12 lpm) requires 19 seconds.

11 lpm, 21 seconds.
10 lpm, 23 seconds.
9 lpm, 25 seconds.
8 lpm, 28 seconds.
7 lpm, 32 seconds.
6 lpm, 38 seconds.
5 lpm, 46 seconds.
4 lpm, 54 seconds.
3 lpm, 76 seconds.
2 lpm, 115 seconds.

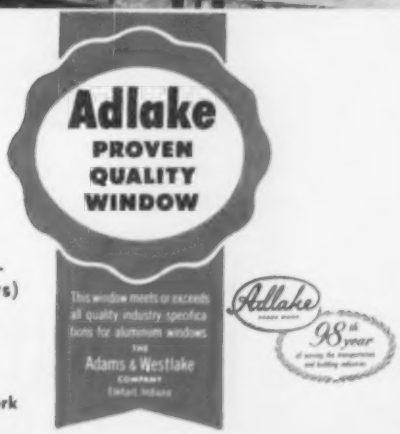
—ARTHUR H. PARKER, *chief engineer, Monadnock Community Hospital, Peterborough, N. H.*

Another **Adlake** aluminum window installation



East Unit, Baptist Memorial Hospital, Memphis, Tenn.
Architects: Office of Walk C. Jones, Jr.
Consulting Architects: Samuel Hannaford & Sons
General Contractor: Harmon Construction Company
Equipped with Adlake Series 1000 Reversible Window

- Minimum air infiltration
- Finger-tip control
- No painting or maintenance
- No warp, rot, rattle, stick or swell
- Guaranteed non-metallic weatherstripping (patented serrated guides on double hung windows)



The Adams & Westlake Company

Established 1857 • ELKHART, INDIANA • Chicago • New York

Superior broad-spectrum antibiotic with fewer

POLYCYCL

TRADE MARK

POLYCYCLINE
CAPSULES

100 mg. — bottles of 25 and 100.
250 mg. — bottles of 16 and 100.

POLYCYCLINE
SUSPENSION '250'

Ready for use . . . requires no reconstitution.
250 mg. per 5 cc. — bottles of 30 cc.

Detailed information on request

BRISTOL LABORATORIES INC.

SYRACUSE, NEW YORK

side effects

INE

(TETRACYCLINE BRISTOL)

Note these advantages:

MORE EFFICIENT ANTIBIOTIC ACTION *with POLYCYCLINE than with older analogues* chlortetracycline and oxytetracycline. Polycycline is *more soluble* than chlortetracycline and is thus more rapidly absorbed and more widely diffused throughout the body. And, because Polycycline is also *more stable in solution* than either analogue, higher serum concentrations are achieved, even in the spinal fluid, and these levels are maintained for a longer time.

WIDE RANGE OF INDICATIONS *for POLYCYCLINE ...similar to its older analogues.* The broad-spectrum antibiotic efficacy of Polycycline includes both gram-positive and gram-negative bacteria, as well as certain rickettsiae, large viruses, and organisms developing resistance to penicillin.

FEWER SIDE EFFECTS *induced by POLYCYCLINE than by either analogue.* An important clinical advantage in the use of Polycycline is the greatly reduced frequency and severity of such reactions as nausea, vomiting, and diarrhea—which so often necessitate termination of treatment with older broad-spectrum antibiotics.

POLYCYCLINE
INTRAMUSCULAR

For deep intramuscular injection. In single dose vials, 100 mg. per vial.

POLYCYCLINE
PEDIATRIC DROPS

For precision administration of small doses. 100 mg. per cc. — bottles of 10 cc. with dropper calibrated for 25 and 50 mg.

Requires no refrigerator space— since all dosage forms of POLYCYCLINE are stable for long periods at room temperature

Stock all dosage forms for the convenience of your staff

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK

General Electric announces the

. . . a moderately priced, highly versatile diagnostic x-ray unit

Featuring . . .

a compact, lightweight spot-film device and maneuverable, space-saving overhead tube support

For fluoroscopy . . . for radiography—General Electric's new REGENT offers radiologists outstanding facilities. New ease and convenience is found in the compact spot-film device. One of the lightest ever offered, it also assures fast, simple operation . . . accepts either 10x12 or 8x10 cassettes . . . provides eight field sizes. It's available with or without phototiming.

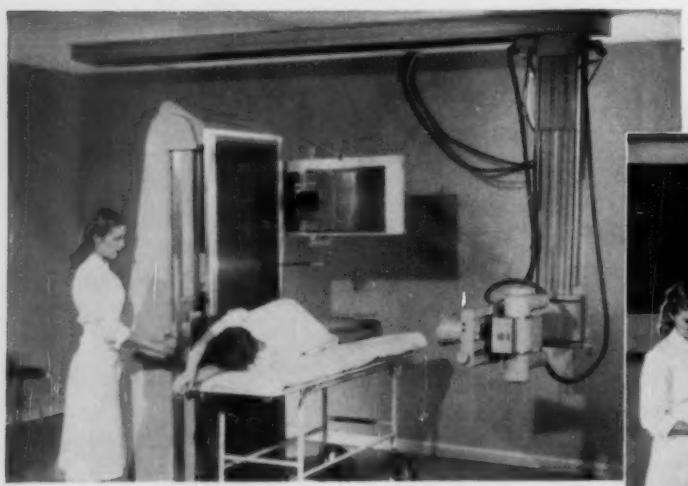
For radiography the REGENT offers an overhead tube support that's instantly positioned for all technics — including all cross-table, decubitus or hospital-cart radiography. The unit provides increased working space around the table . . . is easily parked out of the way when not in use.

In appearance, too, the REGENT is outstanding. Its modern styling — in a pearl-gray finish — fits any setting.

Equally important — with the REGENT you get a product backed by the prestige of General Electric . . . in keeping with your own fine standards. Research, engineering, manufacture, service — all are performed with the skill and care you naturally associate with General Electric.

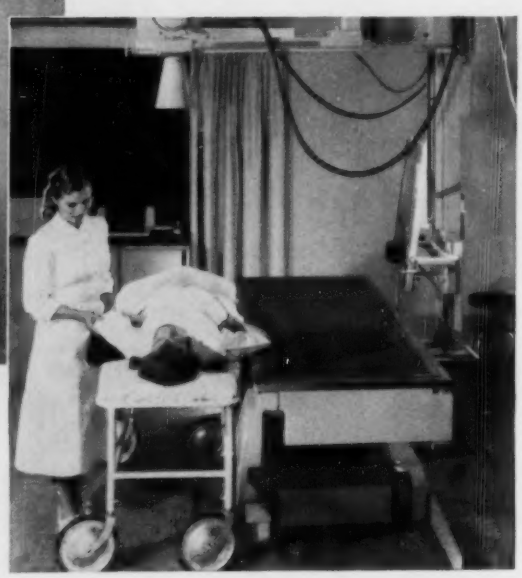
Like all G-E x-ray apparatus, the REGENT can be yours — without initial capital investment — on the General Electric Maxiservice® rental plan.

Ask your G-E x-ray representative to show you how the REGENT can add ease and facility to your radiography and fluoroscopy. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wis. for Pub. L-31.



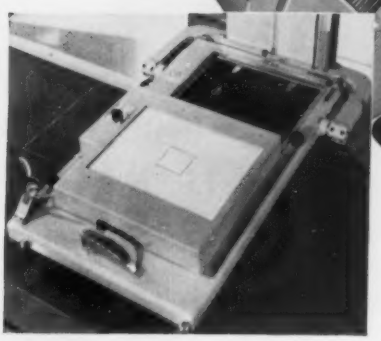
Decubitus Bucky radiography of cart patient can be done routinely at focal-film distances up to 60 inches. REGENT is also available with conventional tube stand, floor-to-ceiling or platform mounted.

REGENT'S overhead tube support facilitates hospital-cart radiography—tube can be positioned well beyond table front.



REGENT

45° TRENDELENBURG fulfills requirements for virtually all technics. Hydraulic tilting mechanism is foot-pedal controlled — moves table smoothly and quietly at any speed you prefer.



REGENT utilizes Scholz lightweight duplex spot-film device with Scholz optical phototiming pickup or sealed G-E unit as pictured.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Aid patient recovery with the new Honeywell Round!

GOOD NEWS FOR A NEW LOW-COST ROOM

Individual Room Temperature Control now possible . . . room by room . . . to fit your budget.

HERE'S a *simple* new thermostat system – the Honeywell Round – that can be installed in your present hospital for as little as $87.50 per room.*

Start *right away* with the Honeywell Round – have it installed in any heating "trouble spots" you may have. Then, as your budget permits, you can have it installed room by room throughout your hospital.

Installation of the Round is *easy* . . . you don't have to tear up floors or walls . . . *you don't even have to redecorate.* Tiny, simple wiring is used with a Honeywell automatic radiator valve and a miniature transformer.

Today physicians and surgeons in many modern hospitals can prescribe *exactly correct* room temperatures to help speed patient recovery. But this medical practice is possible *only with a thermostat in every room.*

This is the only method that can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room.

This Honeywell Round System is especially designed for existing hospitals.

But whether you're modernizing your hospital or building a new one, Honeywell has the Hospital Thermostat System to suit your particular needs.

Just call your local Honeywell office for complete information. Or, write to Honeywell, Dept. HO-3-201, 351 East Ohio Street, Chicago 11, Illinois. Ask, too, for your free copy of the interesting new booklet, "Does this happen in your hospital?"

**Average installed price for room with one radiator.*

72° **In room 210,** a maternity patient is resting while she waits to be discharged. Her doctor felt that a temperature of 72° would contribute most to her sense of well being. This is easily possible with the Honeywell Hospital Thermostat installed right in her room.

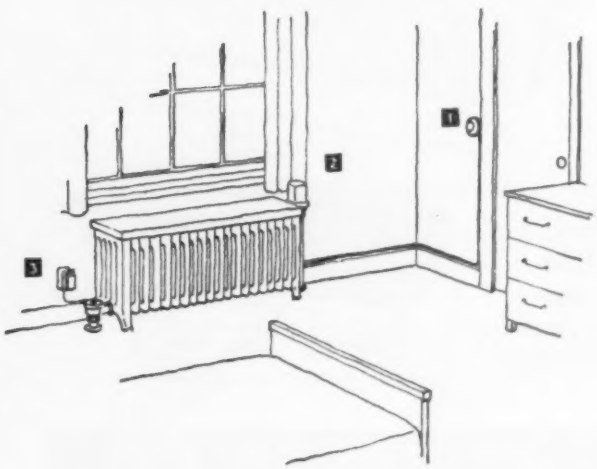
77° **In room 310,** this active youngster is recovering from minor surgery. Because this hospital has Honeywell Individual Room Temperature Control, the temperature in his room can be set at 77°. This gives a proper environment even if he kicks off his blankets.

EXISTING HOSPITALS—
THERMOSTAT SYSTEM!

The new Honeywell
Round features . . .

- **An easy-to-read dial.**
- **Economical installation—no redecorating necessary.**
- **Tamper-proof protection—settings and cover can be locked in place.**
- **Sealed, lint-proof mechanism—insures maintenance-free, dependable operation.**
- **Smart appearance—cover can be painted to blend with any color scheme.**
- **Versatility—can be used with any type heating system or window type cooling unit.**

Actual Size



The sketch at left shows how easily the Honeywell Round System can be installed in individual rooms in *your* hospital. The attractive thermostat (**1**) blends with the wall . . . it's connected to a Honeywell automatic radiator valve (**2**) and a miniature transformer (**3**) by a tiny wire. It's just as simple and economical as it sounds!

MINNEAPOLIS
Honeywell

Hospital Temperature Controls

112 OFFICES ACROSS THE NATION

POLAR WARE goes all the way to meet your requirements in Catheter Trays

No. S-3004

No. S-170

In catheter trays — as in everything else — Polar will go to any length to meet the needs of the hospital clinic for enduring, aseptic stainless steel ware.

This super-long, thirty-inch tray is a case in point — produced by Polar to meet the sterilizing and storage requirements of the new rigid-type plastic catheters. And like all Polar Catheter Trays, it features seamless, heavy-gauge stainless steel construction, with rounded corners for absolute sterility.

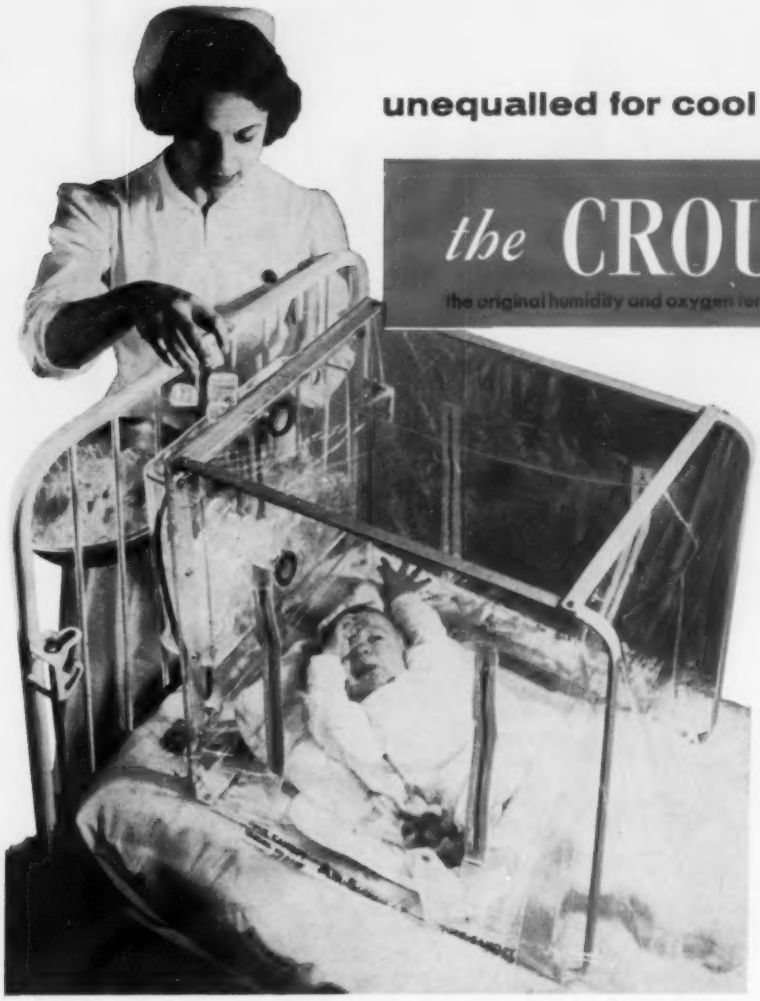
No. S-125

You're sure to find just what you are looking for in the complete Polar line — and often, as in this thirty-inch tray — you can't even find it anywhere else. For this big reason, and many more, the best supply houses from coast-to-coast carry Polar Ware. Ask the men who call on you about this leading line.

No. S-83

Polar Ware Co. * 3500 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54 Room 1100-1101 | *415 Lexington Ave. New York 17, N. Y. | *123 S. Santa Fe Ave. Los Angeles 12, California | Offices in Other Principal Cities *Designates office and warehouse



unequalled for cool vapor therapy

the CROUPETTE®

the original humidity and oxygen tent

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION AMERICAN MEDICAL ASSOCIATION

Outstanding for these features

RECIRCULATION SYSTEM

. . . exclusive and patented—the only system that provides real cooling by recirculating moistened air.

EASE OF OPERATION

. . . uncluttered, all controls outside of tent . . . no hard-to-reach, hard-to-fill ice trays and atomizer assemblies inside.

SAFETY

. . . nothing inside the tent that a child can bump into or tamper with.

ECONOMY

. . . low pressure operation, no high pressure lines or tubing . . . operated with motor compressor★ when oxygen is not needed.

More than 2000 hospitals have 1 to 24 CROUPETTES in use, providing cool vapor therapy—with or without oxygen—for infants, children and adults.

★ Sold separately . . . Air-Shields' new diaphragm-type Compressor-Aspirator runs entirely without oil.

For complete information, write to:

AIR-SHIELDS, INC.

Hatboro, Pa.

manufacturers of

the **ISOLETTE®** The Air-Conditioned Infant Incubator
the **VAPOJETTE*** Supersaturation Attachment
the **ROCKETTE®** Rocking Resuscitator

**Trade-Mark*

ANOTHER IMPROVEMENT

CROUPETTES are now equipped with the new "push-in" glass and plastic atomizer . . . finer fog, easier to clean, completely erosion-proof. Nominal in cost, can easily be installed on any CROUPETTE.

AMES
COMPANY, INC.

manufacturers of *Decholin,*® *Decholin Sodium,*® *Decholin* with Belladonna, *Clinitest,*® *Acetest,*® *Ictotest,*® and other adjuncts in clinical management

announces that it has merged into its research, production and professional service programs, the facilities and products of the fifty-year old

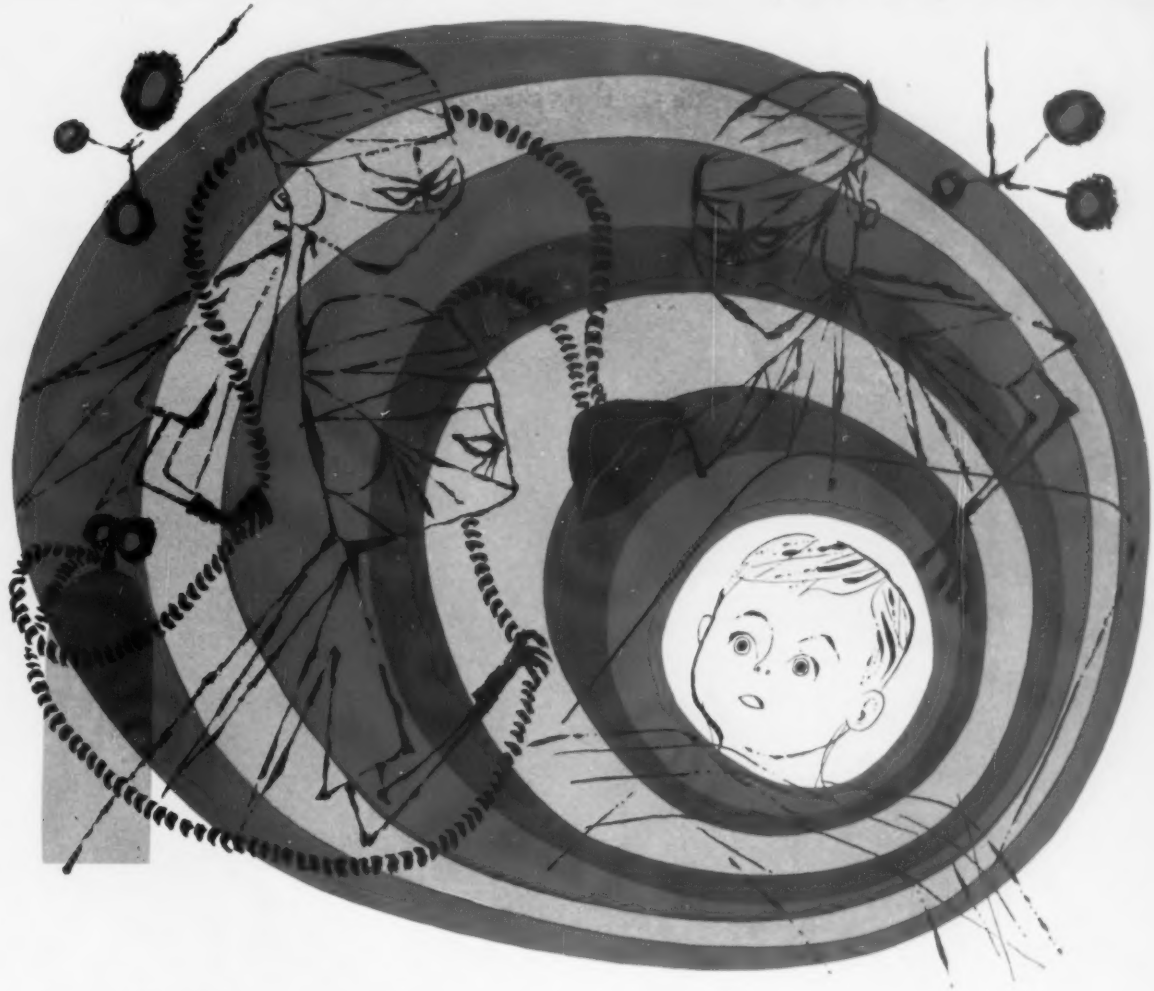
ERNST **BISCHOFF**
COMPANY, INC., IVORYTON, CONN.

manufacturers of *My-B-Den,*® *Aminet*® *Diatussin*® and *Bi-co-tussin

*TRADEMARK

AMES COMPANY, INC · ELKHART, INDIANA

64188



No Nightmare of Fear . . . no pain . . no memory

A really humane way to quiet frightened children

With PENTOTHAL Sodium administered rectally, your pediatric patient goes to sleep in his own bed, wakes there afterwards. *Gone is the shocking glimpse of the operating room . . . the stark, gowned figure . . . the fighting gasp to breathe.*

A versatile, enormously useful anesthetic agent

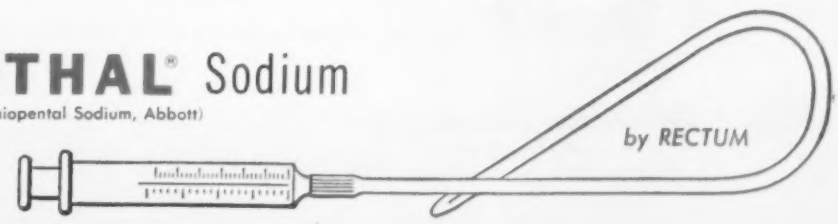
Levels ranging from preanesthetic sedation to basal anesthesia are yours easily, painlessly with Rectal PENTOTHAL. As an adjunct to general anesthesia, it may reduce dosage of inhalation agents, lessen postoperative discomfort. In minor but painful procedures, it may serve as sole agent.

Abbott

PENTOTHAL® Sodium

(Sterile Thiopental Sodium, Abbott)

by RECTUM



503101

from A amputation

to zoacanthosis*

*As a preoperative skin disinfectant.

it's dependable

antisepsis

with quick acting economical

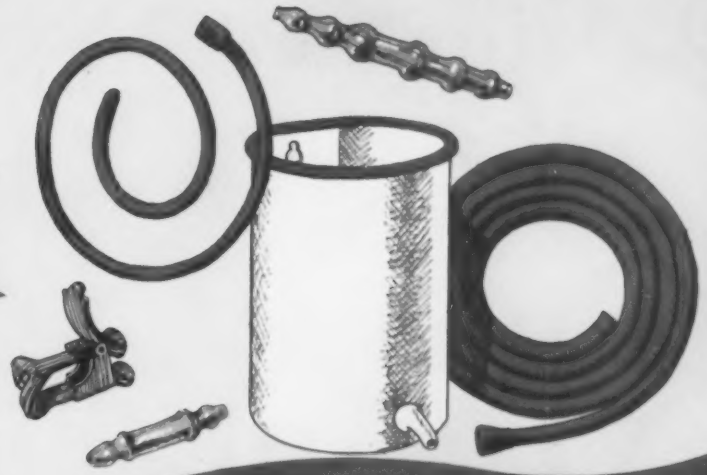
Zephiran® CHLORIDE

high germicidal potency • low toxicity • nonirritating

WINTHROP Winthrop-Stearns INC. New York 18, N.Y. • Windsor, Ont.

Zephiran, brand of benzalkonium chloride (refined)

THIS



REPLACES THIS

Pharmaseal Enema
safe, fast, effective
evacuation

PHARMASEAL°

PHARMASEAL LABORATORIES
Subsidiary of Don Baxter, Inc.
1015 Grandview Avenue, Glendale 1, California

PHARMASEAL®

the finest line of plastic tubes

for greater versatility

THE COMPLETE PHARMASEAL LINE INCLUDES:

- Stomach Tubes (Levin type)
- Oxygen Catheters
- Oxygen Connecting Tube
- Feeding Tubes
- Urinary Drainage Tubes
- Gastrointestinal Tubes
- Gastroenterostomy Tube
- Rectal Tube

all priced for expendability

new ——— K-60 Plastic Suction Catheter specially designed for aspiration of mucus from the trachea. Smooth, molded eye. Whistle tip. Pharmaseal quality construction.

write for free samples

Pharmaseal Laboratories *subsidiary of Don Baxter, Inc.*

1015 Grandview Avenue . . . Glendale 1, California

PIONEER

Announces Another Surgical Glove Extra...

ROLLPRUFS®

with Multi-Size Markings

7 7 7 7 7 7

and... COLOR BANDS

Speeds Glove Sorting

A COLOR FOR EVERY SIZE

Size 6½ - Blue Band . . . Size 7 - Red Band

Size 7½ - Black Band . . . Size 8 - Green Band

All other sizes - Yellow Band

New Color Band size code combined with Multi-Size Markings makes Rollprufs twice as easy to spot in sorting pile. Glove sorting is easier, faster and less expensive.

Rollprufs' exclusive flat-banded beadless cuffs stay in place over sleeves—no roll to roll down. Flat banding strengthens cuffs, reduces tearing.

Only finest virgin latex is used for PIONEER Rollprufs. Specially processed by PIONEER, Rollprufs are chemically stable, no offensive odor—stand many extra sterilizations. Sheer for utmost fingertip sensitivity.

Specify PIONEER Rollprufs for extra money-saving features. Available from leading Surgical Supply Houses.

the PIONEER Rubber Company

349 Tiffin Road · Willard, Ohio

Makers of Fine Surgical Gloves for over 35 years.

WHY CRANE DURACLAY IN LARGE HOSPITAL

New Mazel House Addition to Chicago's Edgewater Hospital specifies CRANE

Large hospital plumbing fixtures are frequently subject to severe thermal shock while in use. The result is crazing and cracking of the fixture . . . and a need for replacement long before it has given its money's worth in service.

But that doesn't happen when you have Crane fixtures.

Because large Crane hospital fixtures are made of Duraclay—a special vitreous glazed earthenware developed in the Crane laboratories.

Mazel House Addition, Edgewater Hospital, Chicago, Illinois. Architect: Edward P. Steinberg. General Contractor: Gust K. Newberg Construction Co. Plumbing Contractor: World Plumbing Company.

Crane Maye surgeons scrub-up sink of Duraclay, permits surgeon to scrub to shoulder without touching non-sterile parts of fixture. Dial-ese foot pedal mixing valve for hot or cold water, or mixed flow.

CRANE

IS A MUST FIXTURES

Duraclay is unaffected by thermal shock and is impervious to acids and stains that affect ordinary hospital fixtures.

Crane offers a complete line of hospital fixtures, all designed in cooperation with hospital authorities for specific hospital use. All are equipped with famous Dialese controls.

Why not talk to your architect about the complete line of Crane hospital fixtures before you build, remodel or replace?

Crane Yale wash-up sink of Duraclay with foot pedal mixing valve which may be elevated to clean the floor. At left of picture, is pre-natal shower with thermostatic control valve and dial thermometer volume control. Hose and shampoo attachment. Vacuum breaker safeguards sterile water supply.

Patient's bathroom with Crane Whirlton siphon jet closet with integral bedpan lugs. Crane bedpan cleansing fixture, Neuday porcelain enamel bath, and Norwich vitreous china lavatory.

Crane pre-natal bath of Duraclay. Cut-out sides for ease of access. Thermostatically controlled water supply. Vacuum breaker safeguards sterile water supply against siphonage. Deviator spout for diverting water to spray.

CRANE CO.
General Offices: 836 S. Michigan Ave., Chicago 5, Ill.
VALVES • FITTINGS • PIPE • KITCHENS • PLUMBING • HEATING

CRANE STARTS ITS SECOND CENTURY OF QUALITY
Founded July 4, 1855

first choice

FOR THIS IMPORTANT "TREATMENT" IN COUNTLESS HOSPITALS!

In many hundreds of America's hospitals, bathing patients with pure, gentle Ivory Soap is routine practice. Patient comfort is a precious thing . . . a soothing bath is welcomed by sick folks.

For 75 years Ivory has been intimately associated with hospital life. Understandably so, for no other soap combines so many fine qualities – at so modest a cost.

You will find Ivory unusually well fitted to serve the personal cleansing needs in *your* institution.

IVORY SOAP— 99 44/100% PURE— IT FLOATS!

MORE DOCTORS ADVISE IVORY THAN ANY OTHER SOAP!

Procter & Gamble

CINCINNATI, OHIO

CHAMBERLIN HAS INSTALLED MORE PSYCHO-SECURITY SCREENS
THAN ALL OTHER COMPANIES TOGETHER

Chamberlin Psycho-Security Screens

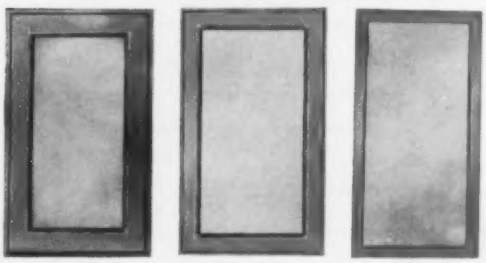
OVER 100,000 IN USE TODAY

In the endeavor to bring peace and ultimate recovery to disturbed patients, Chamberlin Psycho-Security window screens are like a firm hand in a velvet glove. Disguised as familiar insect screens, they imply no sense of restraint and yet prevent self-injury, suicide and escape. Yes, Chamberlin Psycho-Security screens provide protection in every way and contribute to the peace of mind of all who share the responsibility for the patient's care and treatment.

In case of fire or emergency. Chamberlin Detention and Protection type screens may be had with an emergency lock-release mechanism for quick rescue from the outside. There is no better way to avoid a tragedy, not to mention the public criticism and condemnation that is sure to follow.

Consult our advisory staff. You will find no other concern can match our staff in Psycho-Security screen knowledge and experience. They will advise you and save you money by recommending the particular type of screen necessary to provide adequate security for the risks involved.

3 Psycho-Security screens meet these needs



Detention Type | Protection Type | Safety Type

Our "Detention type" to withstand the fury of violent attacks; the "Protection type" for patients who are non-violent but whose detention must nevertheless be fully insured; the "Safety type" where mildly or temporarily disturbed patients are voluntarily confined, but in need of protective custody.

Insist on

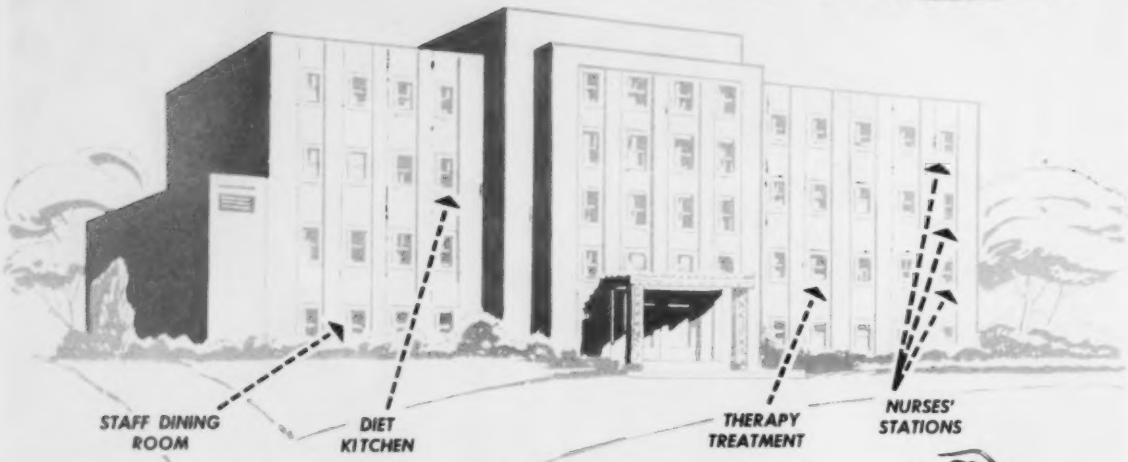
CHAMBERLIN
CHAMBERLIN COMPANY OF AMERICA

unequalled for security

CHAMBERLIN COMPANY OF AMERICA
Special Products Division
1254 LA BROSSE STREET • DETROIT 32, MICHIGAN

CHAMBERLIN INSTITUTIONAL SERVICES also include Mineral Wool Insulation, Metal Weather Strips and Caulking, Metal Combination Windows and Doors, Metal Insect Screens, Aluminum and Fiber Glass Awnings.

SCOTSMAN ICE MACHINES
on every floor!



Save time . . . Save work . . . Save Money

Whatever your ice needs — there is a SCOTSMAN Automatic *Super Flaker* or *Super Cuber* to meet every one. The SCOTSMAN SC-100 *Super Cuber* is ideal for stations on every hospital floor. This low priced efficient *Super Cuber* will save time, work and money by providing low cost, sparkling, sanitary Super Cubes . . . big, round, solid, longer lasting cubes.

When flaked ice is needed for cold packs or therapy the SCOTSMAN *Super Flaker* supplies dry, hard, free-flowing Super Flakes. Super Flakes are made quietly without grinders, choppers or knives, using a mechanism which is the most dependable, yet simplest, ever designed.

Warm weather brings heavy ice demands. Now is the time to write for complete information and facts about SCOTSMAN —America's only complete line of ice machines designed and priced for every hospital need.

For kitchen and staff dining rooms SCOTSMAN Super Cubers are available in sizes which produce from 110 to 500 pounds of big, sparkling, pure, solid, round Super Cubes daily. Super Cubes are made with the exclusive SCOTSMAN "Cycle-Matic" control that guarantees perfect cubes every harvest—cubes that are actually purer than the water from which they are made!

Super Cubers produce up to 500 lbs. of cubes daily.

Super Flakers produce up to 1050 lbs. of flaked ice daily.

AMERICAN GAS MACHINE CO.
Division of Queen Stove Works, Inc.
Dept. H35 • Albert Lea, Minnesota

Please send me full information on SCOTSMAN Ice Machines

Name_____

Address_____

City_____ **State**_____

We've squared the circle—
TO GIVE YOU MORE USABLE STERILIZER SPACE
a change from cylindrical
TO SQUARE STERILIZERS INCREASES LOADING
CAPACITY BY 35%-100%
(Depending upon type of load)
For further information ask for
catalog C-162 • Dept. HB-3
AMERICAN
STERILIZER
Erie 6 • Pennsylvania

Computation of nursing hours

We are wondering what personnel should be included in computing daily average hours of nursing care per patient. We exclude supervisors, head nurses, assistant head nurses, ward secretaries, and orderlies. Also, patients having one or more private duty nurses are counted for only the portion of time when they do not have a private duty nurse. Is this the generally accepted practice?

In the computation of daily average hours of nursing care per patient, it is the custom to include only those persons *who give actual bedside care to patients.* This usually means exclusion of supervisors, some head nurses, and ward secretaries but inclusion of assistant head nurses, orderlies, and nurses aides. The National League for Nursing uses as a criterion for inclusion the question of whether or not the type of worker under consideration, as a group, routinely give bed baths to patients.

Including patients having one or more private duty nurses for only the portion of time when they do not have a private nurse is generally accepted procedure.—SARAH H. HARDWICKE, M.D.

Social security expense

To what account do we charge the social security expense that is paid by the hospital?

We would suggest that social security expense paid by the employer be included in the administration and general expense group. It should be charged to account No. 610-3 Insurance and Bonding as outlined on page 85 of Section 1 of the American Hospital Association *Handbook on Accounting, Statistics and Business Office Procedures for Hospitals.* If the hospital wishes the expense isolated, a subaccount could be set up for it.

The theory behind this accounting entry is that all direct expense of one type or of a similar nature should be accumulated within one departmental or functional account group. Thus, if the hospital does a cost analysis, it can be reasonably assured that expenses of one type or nature have been accumulated in one expense account, aiding in analyzing the expenses.

If the policy of charging social security expense to the individual departments is followed, this approach should be carried out for other types of administrative expenses also, such as fire insurance, professional liability insurance, and the like. The same approach then would be necessary for other expenses, such as depreciation on equipment and maintenance and repair.—RONALD A. JYDSTRUP.

Planning remodeling

We are going to remodel the space occupied by our kitchen storeroom, dietary office, and dining rooms, eliminating a corridor in the process. Should this necessarily be done under the guidance of an architect?

It would be our recommendation that you do retain an architect to analyze the over-all problem and plan the remodeling. It is unlikely that any real saving would be realized by attempting the work without professional assistance. On the contrary, needless expense and regrets may be experienced. As in medicine, the diagnosis and management of the problem are as important as the prescription. Someone must do the planning and supervision. The architect is best qualified and can do the work most expeditiously. — CLIFFORD WOLFE.

Power of attorney on records

May a physician sign a power of attorney to a professional but nonmedical person in his employ in regard to his signature alone on all medical records? This power of attorney would exclude all medical orders but would include all other orders in regard to completion of a patient's chart.

The power of attorney cannot be delegated to a nonmedical person by a physician for the purpose of performing what is essentially the practice of medicine.

We would oppose this on two counts. First, since medical records are maintained for the benefit of the patient, the service that a physician renders to a patient includes the keeping of these records. Secondly, the agreement that the physician has with the hospital when he accepts a position on the staff includes the keeping and maintenance of proper medical records as required by the hospital.

It is possible that the employee of a physician might very well complete medical records on his behalf. Since the medical record department is a part of the hospital, however, it would not be proper for the physician involved to delegate such power to the hospital employees.—CHARLES U. LETOURNEAU, M.D.

Laundry service

In the planning for the construction of a 50-bed hospital, we must decide upon the type of linen-laundry service that would be best—linen rental, commercial laundry, or our own hospital laundry. What would you suggest?

The Committee on Laundry Management of the American Hospital Association believes that most hospitals can operate a laundry efficiently. They are fully aware that a small hospital may have some unique problems and that much depends upon the availability of a commercial laundry. Actually, a complete survey of the individual situation would be indicated. Therefore, it may be well to have a laundry equipment concern make a survey of the hospital working drawings and estimate the cost of a laundry installation. Major firms will be glad to do this at no cost to the hospital.

If, for some reason, the hospital cannot operate its own laundry and a commercial laundry is available, it may be wise to buy, rather than rent, your own linens and have them laundered commercially.—JOSEPH A. WILLIAMSON.

Utilizing operating room time

Can you give us any information on the most efficient utilization of operating room time? Should operations be scheduled for afternoons or Saturdays?

Many hospitals have been interested in the question of efficient utilization of operating room time, usually because in periods of peak patient loads, they have found that

---

The answers to the above questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

FOR PRODUCTS YOU MUST DEPEND ON

QUALITY IS YOUR BEST ECONOMY

IT'S YOURS IN GOMCO® PUMPS

Gomco No. 789
Portable Aspirator

Your safest—and most economical—choice of aspirators is a make that has thoroughly proved itself. And the thousands of Gomco Aspirators in daily use are doing just that.

For we at Gomco *know* there's no short cut to quality. The Gomco pump, built with watchmaker's precision — the Gomco Safety Overflow Valve that prevents overflow damage to the pump — the Gomco overlapping rubber bottle cap that can't work loose — the attractive finish and sturdy gleaming plastic base — are all extra features we include for this reason. We *know* users want aspirators that *won't* be spending time in repair shops — that will last indefinitely — that will be convenient and efficient and quiet in use.

Don't be misled by price or looks. For aspirators you'll be glad you bought years from now, ask for GOMCO.

Suction, Suction-Ether,
and Suction-Pressure Pumps
Thermotic Drainage Pumps
Thoracic Pumps
Aerosol Penicillin Pumps
Dental Aspirators
Tidal Irrigators

GOMCO SURGICAL MANUFACTURING CORP.
820-H East Ferry Street **Buffalo 11, New York**

inability to get patients on the surgical schedule has created a bottleneck for admissions. This has led to local investigations of the possibility of extending the operating room schedule into the afternoon or of including Saturdays in cases where this has not been the practice. In solving this problem other factors must be considered, including (a) operation and staffing of the recovery room, if the hospital has one; (b) staffing the operating room, and (c) returning patients to patient floors in the late afternoon. In other words, the local situation usually includes many factors that will determine whether or not such extensions of the schedule will work. Many hospitals have found this practical.

Time lost between cases is another problem that has been encountered in many hospitals. It involves the joint planning of many people, including surgeons, nurses, anesthetists and messenger service if such is used in transporting patients to and from wards. In one hospital, additions of surgical instruments that permitted advance preparation of a number of standard sets helped cut down the between-operations period. — SARAH H. HARDWICKE, M.D.

First American hospital

What is the name of the first hospital in America, and in what year was it established?

The first hospital in North America—the Hospital of Immaculate Conception in Mexico City—was built in 1524 by Hernando Cortez, the Spanish conqueror. In 1663 it became the Hospital of Jesus of Nazareth. Source of this information is *Hospital Care in the United States*, a study by the Commission on Hospital Care. The hospital still exists today.

A wealth of historical information will be included in the booklet tentatively scheduled for preparation and distribution by the American Hospital Association as part of the National Hospital Week materials. The development of hospitals in the United States and Canada is covered in the booklet.—HELEN T. YAST

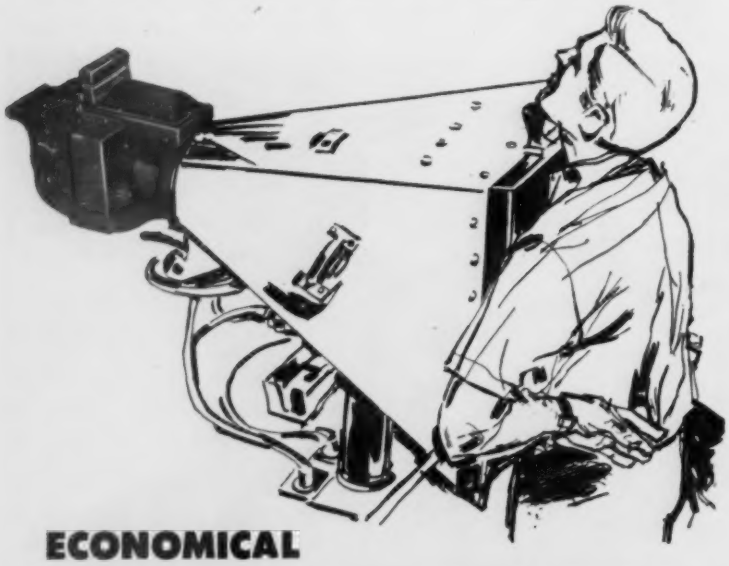
Ideas for insurance program

We are planning to set up a more organized insurance program in our hospital than we now have and would appreciate any suggestions you can make as to who should decide upon the insurance to be purchased.

The Committee on Insurance for Hospitals, in writing a new manual on this subject, has developed a series of ideas that, it believes, outlines an approach to the purchase of a hospital's insurance program. Briefed, they are:

The most commonly accepted reason for the purchase of insurance—one with which the committee agrees—is to protect the financial structure of the hospital corporation. Fire insurance will no more prevent a fire than liability insurance will prevent a law suit. What both will do, however, is provide a source of funds to recover financial loss caused by either of these occurrences.

It is recommended that the insurance-buying policy of the hospital be established at the board-administrator level. This group should determine what insurance is to be purchased and what is not to be purchased. In the event that the hospital does not have the amount of money necessary for a complete program, this group



ECONOMICAL
ADMISSION X-RAY PROGRAMS
made possible by Fairchild 70-mm cameras

Fairchild 70-mm x-ray cameras, used in connection with photofluorographic equipment, provide the easiest and most economical method of carrying out a complete admissions x-ray program—because of their rapid, automatic operation and fractional film costs. As a result, these cameras have become the "standard" for mass chest radiography. The 70-mm negative is adequate for direct viewing; magnification viewing is available if desired. Suspected positive cases (which have been found to average between 8 and 10 per cent of all hospital admissions) would normally be retaken on 14 x 17 film by the hospital radiologist.

The completely automatic operation of the Fairchild Roll Film Camera permits one technician to radiograph up to 150 chests per hour. For smaller hospitals the Cut Film Camera offers identical high negative quality at lower initial investment. Fairchild's 70-mm cameras are available on all leading 70-mm hospital admission units and can be adapted to many existing installations. The cameras are unconditionally guaranteed for one year, and are backed by Fairchild factory service. For further information consult your x-ray equipment supplier or write *Fairchild Camera and Instrument Corp., 88-06 Van Wyck Expressway, Jamaica, N. Y., Dept. 160-35Q3.*

Report of the Council of Tuberculosis Committees, American College of Chest Physicians. April, 1951:

"... We also urge routine chest x rays of all admissions to general hospitals. The value of this has been demonstrated in several large hospitals throughout the country where unrecognized cases of tuberculosis and other chest conditions are being discovered."

FAIRCHILD
X-RAY EQUIPMENT
AND ACCESSORIES

less handling
ties faster
no winding – no waste

allows twice
as many ties
per suture

D & G SPIRAL WOUND

surgical gut
silk* • cotton

DAVIS & GECK INC.
A unit of AMERICAN Cyanamid COMPANY
DANBURY, CONNECTICUT

*ANACAP® BRAND

should determine, for example, whether a little of each is to be purchased or whether certain hazards are to be covered completely and others not at all.

The committee further recommends that, to assist the group in making these decisions, the services of a competent agent or broker or a group or committee of these be obtained — particularly insurance men with extensive connections in the insurance industry.—WILLIAM T. ROBINSON.

Locating infant formula room

We are planning some remodeling in our hospital and are considering moving the infant formula room from the dietary department to the central sterile supply department. A partition seven feet high would separate the two. Is there any reason why this would not be advisable?

The important generally accepted criteria for the location of the infant formula room are that it be in a place of "least possible danger of contamination, particularly from sick infants and children" and that it be apart from an area of heavy traffic. The types of contamination that are most feared in the infant formula room are those from persons, either employees or patients, who are ill with diarrheal infections. Also, recently outbreaks of infantile diarrhea due to *Escherichia Coli* have been given particular attention.

If the central sterile supply room is located strategically from the point of view of receiving supplies and distributing the finished formulas, its autoclaves with their usual temperature recording devices can be used, avoiding duplication of expensive equipment. Many central sterile supply rooms would lend themselves well to this.

While the central supply room usually does receive used equipment from hospital floors, such as intravenous sets, in any well-organized operation the design and work flow are such as to provide separation of "clean" and "dirty" areas. With the formula room further segregated by partitions and doors, cross contamination seems unlikely unless workers proceed from work in the "dirty" area to work in the formula room. We assume that formula room workers will not be given other assignments in the "dirty" area.

The seven-foot partition raises at least the academic question of air-borne contamination. This would be more important in the case of occasional use of formulas that will not stand terminal sterilization, such as some of the cereal and meat preparations. These are rarely used but for an occasional case might be thought desirable. For this reason, it would be desirable, if possible, to make the partitions floor to ceiling and to provide a door to the formula room which would be kept closed.

If heat is a problem in the area, the use of a small air-cooling unit might be considered. One that merely cools and recirculates the air in the room is usually satisfactory and avoids the problem of making sure that outside air is adequately filtered. Some of the small room air conditioners on the market, meant to be placed in windows, do not have adequate filters for this purpose.—SARAH H. HARDWICKE, M.D.

BURTON MANOTEST®

300 mm MERCURIAL All Purpose Pocket Size SPHYGMOMANOMETER

SEALED-IN ACCURACY

Yes . . . *full scale 300 mm mercury measurement with accuracy "SEALED-IN" at the factory!* Use the MANOTEST in your office . . . on your desk or with special wall bracket or portable floorstand. Slip the SAME instrument into your pocket or bag for house calls, with confidence that the Burton MANOTEST'S findings are always comparable. Ideal for every use in hospitals, clinics, offices and schools.

MORE FEATURES with BURTON MANOTEST

Full 300 mm mercury measurement . . . Big easily readable ANGLED scale . . . Leak-proof, can't lose mercury . . . Corrected for position, vibration or shock . . . Special means for keeping mercury clean . . . Impressive NEW LOOK . . . "Quik-Hook" cuff; long tube leads . . . Protective zipper carrying case. Colors: Ivory, Grey or Mahogany.

PRICE ONLY $44.50

Complete with self-adjusting "Quik-hook" cuff, extra long tube leads, bulb and zipper carrying case.

ORDER FROM YOUR DEALER

All-Purpose Burton MANOTEST is Ideal for Hospitals

Recommended for the anesthesiologist, receiving room, emergency room and wherever blood pressure must be taken in hospitals, clinics, etc. Assures the same unvarying calibration and mercury accuracy always!

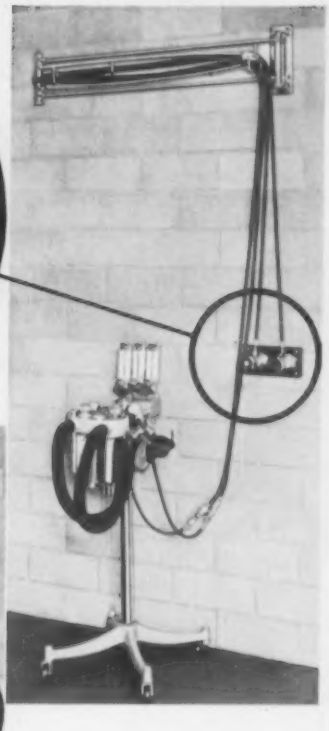
BURTON MANUFACTURING COMPANY
11201 WEST PICO BOULEVARD • LOS ANGELES 64, CALIF.

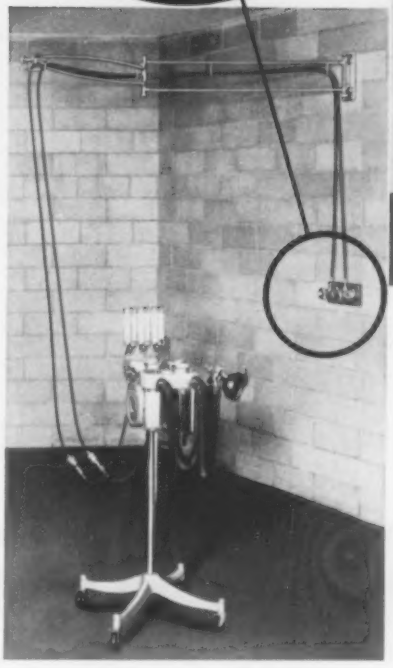
Manufacturer of Precision Pressure Instruments for Professional Use, Aircraft, Armed Forces, Etc.

A Must

for every central oxygen or gas supply system . . .

McKESSON WALL VALVES





Only McKesson makes such valves—

Valves which assure against loss of expensive gases—

Valves which mean maximum safety and convenience—

Valves which have the famed "O"-Ring to stop gas leaks at stem!

Long-life, trouble freedom guaranteed by quarter-century of making these products—

With thousands of McKesson Wall Valves still in daily use after 25 years!

Widest Variety—

Supplied in vertical-type as well as horizontal. Constructed to fit all kinds of boxes and plumbing installations!

Reasonably priced!

Especially popular when used with Schrader Couplers!

CATALOG FURNISHED ON REQUEST.

Practical Adjunct to All Central Gas Systems—
The NEW McKesson Tube-Support Crane

Illustrations show Crane connected to McKesson Wall Valves and Schrader Couplers.

Supports supply tubes six feet from wall at any convenient height, when fully extended.

Folds and lies flat against wall or may be disconnected and stored when not in use.

Designed originally for State University of Iowa.

Brochure available on request.

also,
Central Suction and Piping Systems

Scores of the Nation's leading hospitals have McKesson Central Suction Systems with Terminal Outlets convenient to every operating table. *Brochure with Diagrams Sent by Return Mail.*

McKesson
WALL VALVES

McKesson Appliance Co., Toledo, Ohio

Manufacturers of these major products:

Bronchio Spirometry • Anesthesia • Resuscitators • Suction Pumps • Metabolism • Oxygen Tents • Analgesia • Vital Capacity • Pneumothorax • Air Compressors • Rocking Beds • Dermal Temperature • Oxygen Therapy

NORTH SHORE HOSPITAL
MANHASSET, L.I., N.Y.
Adm., JOHN M. DANIELSON
Ass't Adm., D. A. KINCAID
Food Mgr., HENRY HAUSLI
Dietician, (MRS.) MARGARET KANE

"Mealpack has done wonders for both us and our patients"

—**HENRY HAUSLI**, *Food Manager*
North Shore Hospital, Manhasset, L.I., N.Y.

- Little wonder Mr. Hausli speaks so enthusiastically. For here is what he has seen the MEALPACK SYSTEM accomplish at 185-bed North Shore:
- Eliminate cost of installing and equipping four (4) floor pantries. Net saving, $27,000.
- Reduce pantry personnel. Annual saving, $10,000.
- Reduce raw food cost. Annual saving, $8,000.
- Add revenue from eight semi-private beds. Annual income, $75,000.
- Generate patient enthusiasm with more palatable and nutritious meals, including *selective menus for every tray.*

mealpack

***Write** for the complete MEALPACK story and a list of installations near you*

MEALPACK CORPORATION
A SUBSIDIARY OF AMERICAN HOSPITAL SUPPLY CORPORATION
2014 Ridge Avenue, Evanston, Illinois

Beautiful Rockford Memorial Hospital

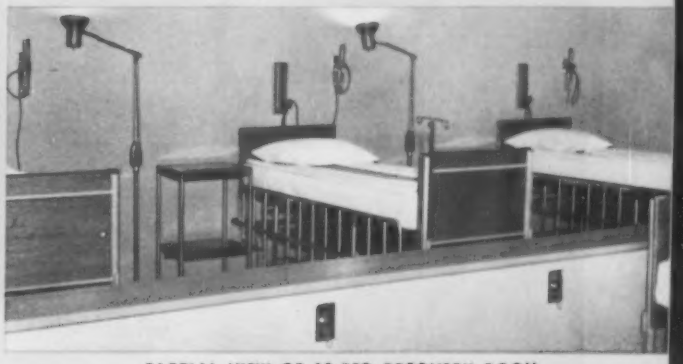
CHOOSES NCG® OXYGEN PIPING EQUIPMENT

The new Rockford Memorial Hospital at Rockford, Illinois, has aroused widespread interest and admiration—not only for its handsome exterior but for the new concepts embodied in its interior design.

And like so many hospitals that are distinguished by the thought and care that goes into their planning, Rockford Memorial chose NCG equipment and NCG oxygen for its oxygen piping system.

ARCHITECTS: Perkins & Will—Hubbard & Hyland.
PIPING CONTRACTOR: Rockford Industries, Inc.

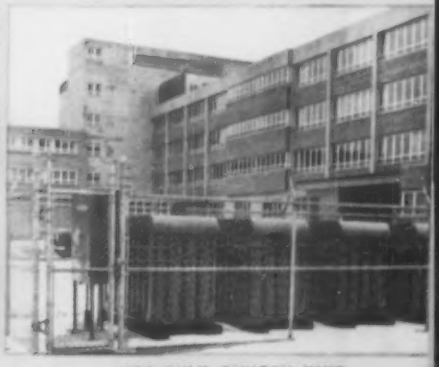
PATIENT'S ROOM



PARTIAL VIEW OF 10-BED RECOVERY ROOM

DELIVERY ROOM

NURSERY



NCG BULK OXYGEN UNIT

Do you realize that a piping system, besides being the most convenient form of oxygen supply *is also the most economical?* Experience shows that an oxygen system pays for itself in savings . . . in less than two years when added to existing buildings, and sooner than that when installed in new construction. NCG's hospital specialists can give you the facts, will be glad to submit preliminary plans and estimates, without obligation to you. Simply write to your nearest NCG office, or to the address at the right.

NCG®

MEDICAL DIVISION

NATIONAL CYLINDER GAS COMPANY

840 N. Michigan Ave., Chicago 11, Illinois

OFFICES IN 56 CITIES

Copyright 1955, National Cylinder Gas Company

BAKER VALUE and quality

Quality, combined with honest value, are the reasons why hospitals from coast to coast, have purchased their linens from Baker for so many years.

Exclusive distributors

Dwight Anchor

SHEETS & PILLOW CASES

•

SANDOW and SAMPSON

BATH TOWELS

•

Batex

HUCK TOWELS

and other quality textiles made especially for hospital use.

H.W. BAKER LINEN CO.

315-317 Church Street, New York 13, N. Y.
and 13 other cities

FOUNDED IN 1892

for
lowest
"cost-in-use"

MULTIFIT®

Syringes

every plunger fits every barrel

B-D MULTIFIT Syringes *cost less to use* because their

- **rate of replacement is lower—**
  the clear glass barrel virtually eliminates loss from friction and erosion.
- **cost of replacement is lower—in case of breakage, you lose only the broken part—the unbroken part remains in use.**
- **ease and speed of assembly cut handling time—**
  free personnel sooner for other tasks.

B-D

BECTON, DICKINSON AND COMPANY
RUTHERFORD, N. J.

B-D AND MULTIFIT, T.M. REG. U.S. PAT. OFF.

Have you tried all three?

"Specialist"®

EXTRA-FAST-SETTING

For clubfoot, fore-arm and other casts where an extremely fast-setting bandage is desired.

2" x 3 yd. 4" x 3 yd.
3" x 3 yd. 6" x 3 yd.

For walking-boots, long-term casts—and wherever maximal strength, minimal weight and effective moisture-resistance are essential.

3" x 3 yd.
4" x 3 yd. 6" x 3 yd.
4" x 5 yd. 6" x 5 yd.

"Specialist"®

FAST-SETTING

The bandage of choice for all general cast work.

2" x 3 yd. 5" x 5 yd.
3" x 3 yd. 6" x 5 yd.
4" x 5 yd. 8" x 5 yd.

Johnson & Johnson

Your Guarantees of Consistent Quality...

1 Unconditionally guaranteed by Will Ross, Inc.

2 Accepted by the A.M.A.

ACCEPTED
COMMITTEE ON COSMETICS
AMERICAN MEDICAL ASSOCIATION

★ Cooling
Soothing
Refreshing

MANUFACTURERS AND DISTRIBUTORS OF HOSPITAL AND SANATORIUM EQUIPMENT AND SUPPLIES

WILL ROSS, INC.

MILWAUKEE, WISCONSIN
ATLANTA, GEORGIA • COHOES, NEW YORK
DALLAS, TEXAS

Why the Curity 5-in-1 Abdominal Pad

ABSORBS MORE DRAINAGE FASTER

than any other pad made!

1. COMPRESSED COTTON . . . *picks up* drainage quickly
2. FLUFFY COTTON . . . *holds* drainage, like a "reservoir"
3. CELLUCOTTON* ABSORBENT WADDING . . . *spreads* drainage by capillarity
4. NON-ABSORBENT COTTON . . . *retards* leakage, protects gowns and linen
5. SEALED GAUZE . . . blue seal identifies waterproof side

Like all *Curity* dressings, the *Curity* Abdominal Pad is built to meet the needs of the wound—built to receive drainage as fast as any wound can deliver it . . . and to *retain* that drainage regardless of its volume, character and consistency. End result: it keeps drainage away from the wound, lets the wound heal naturally.

SAVES MONEY, TOO

The *Curity* Abdominal Pad is actually the *most economical* pad you can use. Inexpensive itself . . . and its greater efficiency means added savings in fewer pads per patient, less nurse time, lower laundry costs. You really can't *afford* inferior pads—why not specify *Curity* Abdominal Pads on your next order?

*Trade-mark of the I.C.P. Co.

Count on *Curity* for
*DRESSINGS THAT WORK

Curity dressings are *functional* dressings—"built from the wound up" to *insure proper healing*. This is the *Curity* approach to better hospital dressings for better patient care. And the greater efficiency of *Curity* dressings means *lower cost per patient*—the true measure of dressings economy.

Curity
REG. U.S. PAT. OFF.

ABDOMINAL PADS

BAUER & BLACK
Division of The Kendall Company
309 West Jackson Blvd., Chicago 6, Illinois

Upjohn

Bacterial diarrheas...

Kaopectate

Trademark, Reg. U.S. Pat. Off.

with Neomycin

Each fluidounce contains:

Neomycin sulfate . . 300 mg. (4⅔ grs.)
[equivalent to 210 mg. (3¼ grs.) neomycin base]
Kaolin . . . . . 5.832 Gm. (90 grs.)
Pectin . . . . . 0.130 Gm. (2 grs.)
Suspended with methylcellulose . 1.25%

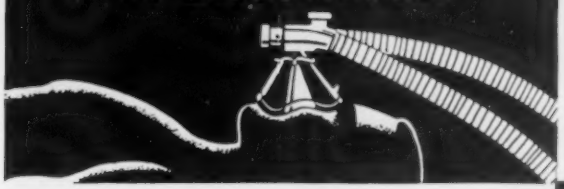
Supplied:

6-fluidounce and pint bottles

The Upjohn Company, Kalamazoo, Michigan

OHIO HEIDBRINK KINET-O-METERS

for unequaled performance in anesthesia

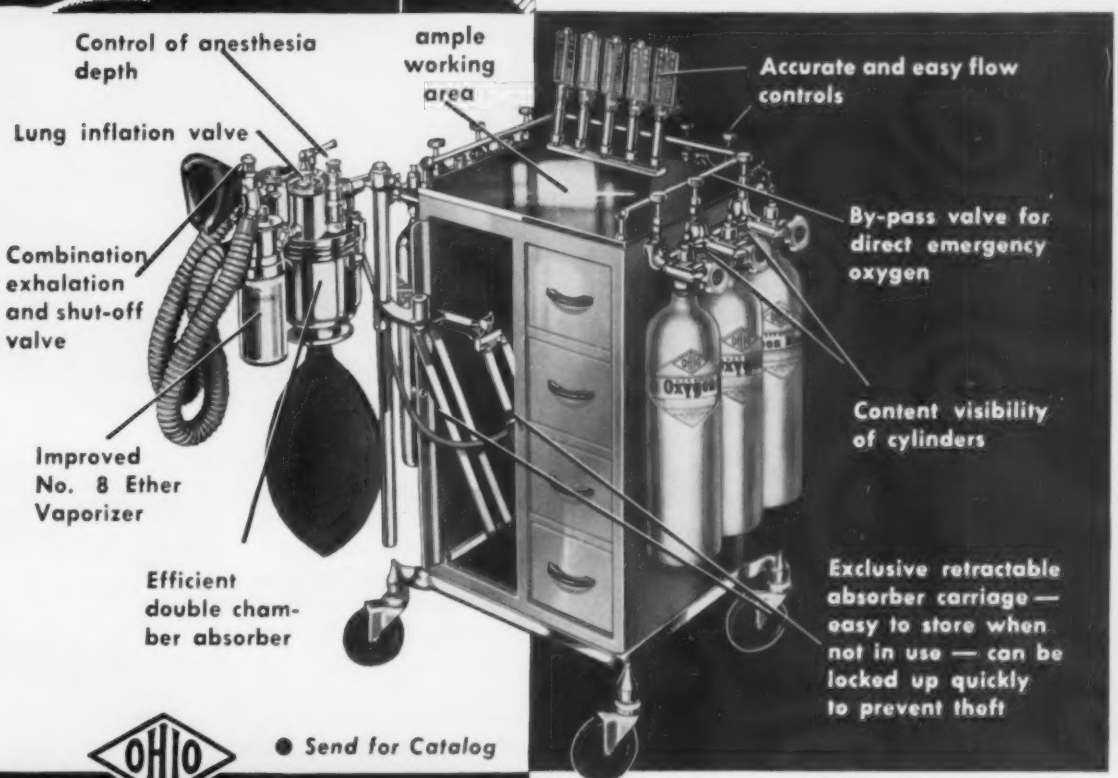


Flexibility — *Suitable for any type of anesthesia — to-and-fro method or circle method*

Ready Accessibility — *all controls within easy reach*

Safety — *Entire circuit protected by complete chain of conductivity*

Dependability — *Meets the needs of the most discriminating anesthesiologist or anesthetist*


Control of anesthesia depth
ample working area
Lung inflation valve
Accurate and easy flow controls
By-pass valve for direct emergency oxygen
Combination exhalation and shut-off valve
Content visibility of cylinders
Improved No. 8 Ether Vaporizer
Efficient double chamber absorber
Exclusive retractable absorber carriage — easy to store when not in use — can be locked up quickly to prevent theft

● *Send for Catalog*

OHIO

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT COMPANY
MADISON 10, WISCONSIN

Ohio Chemical Pacific Company, San Francisco 3
Ohio Chemical Canada Ltd., Toronto 2
Airco Company International, New York 17
Cia. Cubana de Oxigeno, Havana
(All Divisions or Subsidiaries of Air Reduction Company, Incorporated)

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
Dept. H-3, Madison 10, Wisconsin

Please send me catalog 2145 with details on full line of anesthesia units and accessories.

Hospital.....

Address.....

City..... Zone..... State.....

Your name.....

New Autoclave Indicator Tape

"SCOTCH" Brand Hospital Autoclave Tape No. 222
changes color during the autoclave procedure*

BEFORE AUTOCLAVING tape has solid light color

AFTER AUTOCLAVING tape bears identifying brown lines

NO MORE GUESSWORK..."SCOTCH" Brand Hospital Autoclave Tape No. 222 changes color during normal autoclave procedure, tells you at a glance whether the item has been through the autoclave machine. And No. 222 has all of the advantages of the old No. 216 tape. It seals packs firmly, saves half the time ordinarily needed to prepare packs for autoclaving with the conventional methods—pinning, string tying, tucking. This tight-sticking tape holds firmly in high steam temperatures, can be written on with pencil or ink. And most important, it leaves no stains or gummy residue.

***IMPORTANT:** Indicates autoclaving only—Nothing on the outside of a bundle can give positive proof of sterility.

YOUR SUPPLIER has this new tape now, plus the popular hospital-model Definite-Length Dispensers that measure out pre-set lengths of tape. See him today!

Reg. U.S. Pat. Off.

SCOTCH
BRAND

Hospital Autoclave Tape No. 222

The term "SCOTCH" and the plaid design are registered trademarks for the more than 300 pressure-sensitive adhesive tapes made in U.S.A. by Minnesota Mining and Mfg. Co., St. Paul 6, Minn.—also makers of "SCOTCH" Brand Magnetic Tape, "Underseal" Rubberized Coating, "Scotchlite" Reflective Sheeting, "Safety-Walk" Non-slip Surfacing, "3M" Abrasives, "3M" Adhesives. General Export: 99 Park Ave., New York 16, N.Y. In Canada: London, Ont., Can.

Faultless epiderm Surgeons' gloves

COLOR-BANDED . . . easier to sort . . . better to use

Faultless Epiderm Gloves are banded on the upper wrist, have special advantages in sorting and in surgical use. Five different colors identify sizes, avoid errors, save sorting time and trouble. Bands reinforce and strengthen pull-on area, hold glove more securely on sleeve of gown.

Faultless Epiderm Gloves are made of finest natural rubber latex. Have many superior features: Tissue thinness for extra sensitivity. Correct shape and gauge for utmost comfort. Unusual strength and tear resistance. Durability for long life and true economy. Epiderm Gloves are available in color-banded and rolled wrist styles, in white latex and brown latex. Order from your surgical supply dealer, or write.

Homer Higgs Associates, Inc., 200 Fifth Ave., New York 10, N. Y.

Faultless Epiderm Gloves are tissue thin and anatomically shaped for easy flexing. Less tension on fingers and hand, less fatigue. *Purity of highest quality materials assures low incidence to dermatitis.*

The Faultless Rubber Co., Ashland, Ohio

Gentlemen: Please send catalog and full information on Epiderm Surgeon's Gloves; also name of nearest surgical supply dealer.

My name_____ Title_____

Hospital_____

City_____ State_____

The Right Windows make a REAL DIFFERENCE...

Ask your Nurses!

They'll tell you what a difference cheerful daylight and controlled fresh air can make toward a patient's whole outlook, his speed of recovery. And they'll be quick to mention how important it is to have windows that open easily like these Fenestra* Intermediate Combination Steel Windows.

These beautiful windows give you more daylight because they have more glass area, thanks to steel frames that are strong and rigid without being bulky. "Wing" vents reach out to catch the passing breeze and guide it in, wherever you want it. You can have controlled fresh air even when it's raining—the in-tilting vent sheds the rain outside. It also deflects air upward to guard against drafts.

Fenestra windows save you maintenance money, too. They can be cleaned and screened from inside. You need no scaffolds, no expensive crews.

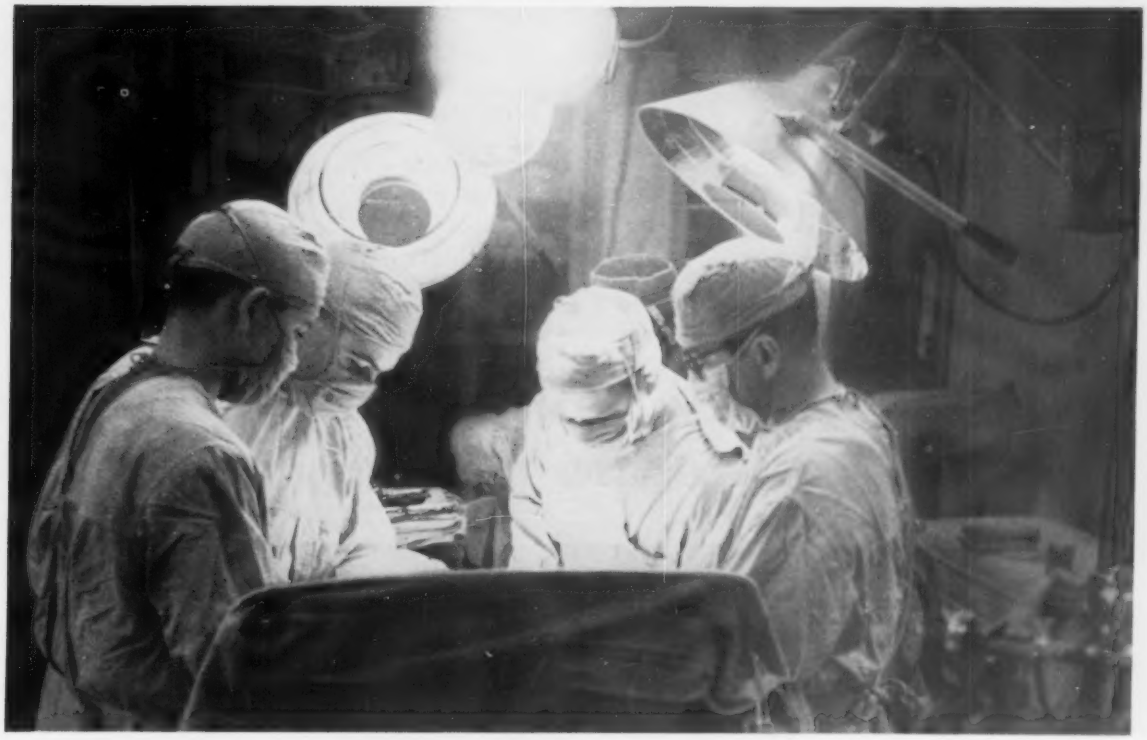
They are also available Super Hot-Dip Galvanized, so no painting is necessary. These galvanized windows cost very little extra and will save you maintenance money for the life of your building.

For complete information, call your Fenestra Representative. He's listed in the yellow pages of your phone book. Or write Detroit Steel Products Company, Dept. H-3, 2292 E. Grand Blvd., Detroit 11, Michigan. *®

Fenestra | **INTERMEDIATE STEEL WINDOWS**

Architectural, Residential and Industrial Windows • Metal Building Panels
Electrifloor* • Roof Deck • Hollow Metal Swing and Slide Doors

Standby Power in O.R. only, *is not enough!*



Let ONAN Standby Electric Plants supply power for <u>all</u> your essential services

Patients, hospital personnel and property may be endangered when any other vital equipment cannot be operated or important service performed . . . especially when the power outage is of long duration.

From the wide range of Onan Electric Plants you can choose a model with the capacity to operate *all essential equipment* . . . automatic heating system, respirators, aspirators, X-ray machines, ventilators, communications, pumps, elevators and lights *for as long as you need these services.*

When power interruptions occur, the Onan Emergency Power System takes over automatically . . . supplies electricity for the duration of the outage . . . and transfers the load back to the regular source of power when service is restored to normal.

MODEL 25HN
25,000 watts A.C.

Free Estimating Service

Let us know what equipment you would like to include in a complete emergency power system and we will recommend the proper equipment and estimate the cost. If you are building a new hospital or remodeling extensively, we suggest that you consult your architect or engineer.

ONAN ELECTRIC PLANTS *are available in a wide range of models and capacities—Gasoline-engine-powered: 400 to 100,000 watts, A.C.*

D. W. ONAN & SONS INC.

Onan ELECTRIC PLANTS

2977 UNIVERSITY AVENUE S.E.
MINNEAPOLIS 14, MINNESOTA

from an editorial in the J.A.M.A.
(156:991, Nov. 6, 1954):

Oral broad spectrum antibiotic therapy
may cause infection with Candida albicans

A new concept in antibiotic therapy

antibacterial therapy
plus
antifungal prophylaxis
in one capsule

Each Mysteclin capsule, containing 250 milligrams of tetracycline hydrochloride and 250,000 units of nystatin, costs the patient only a few pennies more than does tetracycline alone.

Minimum adult dose: 1 capsule q.i.d.
Supply: Bottles of 12 and 100.

MYSTECLIN

SQUIBB TETRACYCLINE—NYSTATIN

antibacterial · antifungal

"MYSTECLIN" IS A SQUIBB TRADEMARK

SQUIBB

POWERS AIR CONDITIONING CONTROL
Helps hasten recovery of patients
To Provide Optimum Thermal Comfort In
Operating Rooms
Recovery and Delivery Rooms
Nurseries, X-Ray
and other spaces in hospitals —
SPECIFY and INSTALL
POWERS
CONTROL
For All Types of Hospital Heating and Air Conditioning Systems
Also Thermostatic Controls for Hydrotherapy Shower Baths Water and Fuel Oil Heaters and Many Other Uses

POWERS One DEPENDABLE Source for All Hospital Requirements of

AUTOMATIC TEMPERATURE and HUMIDITY CONTROL

When you want modern controls for a new or existing building contact Powers. No other firm makes as big a variety of thermostatic controls used in hospitals. For help on any control problem call your nearest Powers office or write us direct. Our more than 60 years of experience in automatic temperature control should be helpful. (b92)

At Your Service in 60 Cities in the U.S.A., Canada and Mexico

Established in 1891 • **THE POWERS REGULATOR COMPANY** • SKOKIE, ILLINOIS

Ritter
MULTI-PURPOSE SURGERY TABLE

with motor-hydraulic elevation

Multi-Purpose Surgery Table in proctologic position

Universal arm rest attached to side rail providing greater access to hand and arm for surgery, splinting and intravenous injections

Strap-type crutches attached for urology work, perineal cut-out removed, pan extended

Designed and equipped to give *you* greater ease of operation. The Ritter Multi-Purpose Surgery Table offers instantaneous, effortless, surgeon-controlled height adjustment. This flexible Ritter Table is completely safe in the operating room . . . the exclusive motor-driven hydraulic base is explosion-proof . . . approved by Underwriter's Laboratories, Inc. Added safety features include static conductive rubberized upholstery, conductive rubber casters and brakes. Hydraulic base controls and back and leg section levers are easily operated from either side of the Table by a light touch. 180° rotation assures maximum accessibility at all times. Then, too, there is a complete line of Ritter designed, custom accessories for most requirements. For complete details see your Ritter Dealer or write the Ritter Company, Inc., Ritter Park, Rochester 3, N. Y.

Ritter

...just call on "Rex" McKay!®

When the busy hospital pharmacist needs a new and possibly unfamiliar pharmaceutical, McKesson's "Rex" McKay service is invaluable... just contact your nearest McKesson Division. "Rex" will have the answer! Another thing—your local McKesson representative is your assurance of these services.

1. COMPLETE STOCKS... YES! You can be assured that McKesson carries the most complete line of pharmaceuticals available.

2. FAST DELIVERY... YES! No matter where you are located, there's a McKesson wholesale division nearby to service your needs.

3. PERSONAL SERVICE... YES! The McKesson representative calls on you at regular intervals, and in emergencies a telephone call to the McKesson Division nearest you will provide rush shipments.

4. LESS DETAIL... YES! You have only *one* invoice when you order through McKesson... only *one* shipment to open and check... only *one* representative to see.

If a McKesson representative is not calling on you at present, or if you want more information, write to McKesson & Robbins, Incorporated, 155 E. 44th St., New York 17, N. Y.

McKESSON & ROBBINS
INCORPORATED

74 Completely Stocked Warehouses from Coast to Coast

ONLY **BARDEX®** Balloons have reinforcing ribs . . .
which assure the uniform distention so necessary for
proper retention and effective hemostasis.

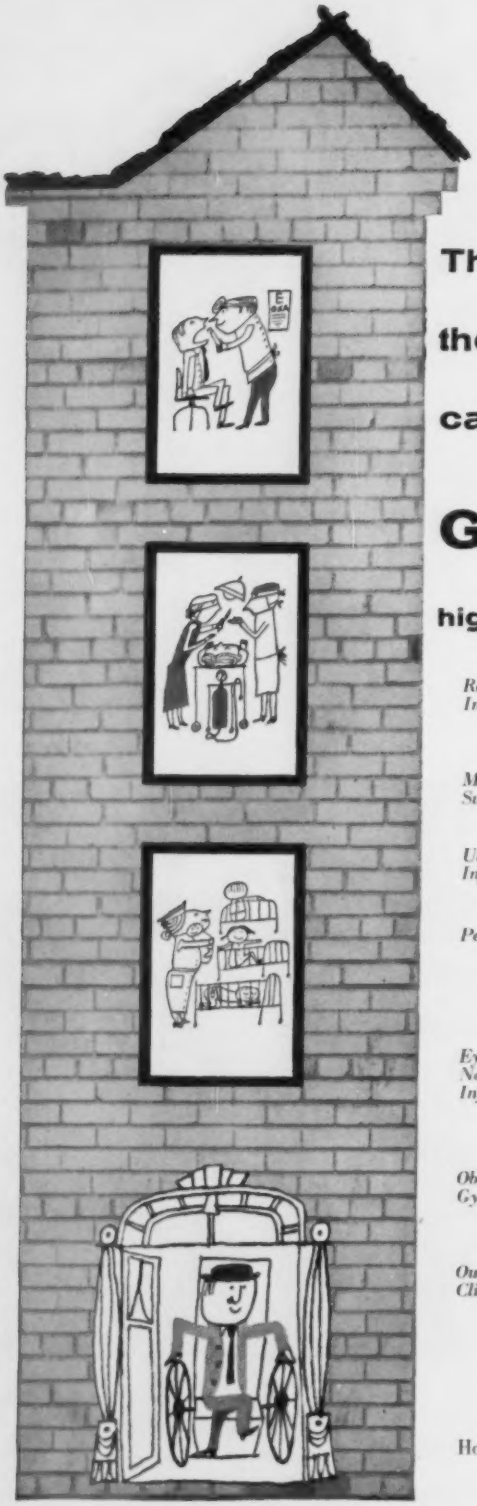
Specify **BARDEX®** Foley Catheters

"The Accepted Standard of Excellence"

Available in 44 styles

C. R. BARD, INC., Summit, New Jersey

editorial notes



Throughout the hospital

there are more and more

calls for

GANTRISIN *'Roche'*

highly soluble, single sulfonamide

Respiratory Infections	tablets, 0.5 Gm each
Meningitis Surgery	ampuls, 5 cc (2 Gm) and 10 cc (4 Gm)
Urinary Infections	tablets, 0.5 Gm each
Pediatrics	pediatric suspension (raspberry-flavored), and syrup (chocolate-flavored), containing the new, tasteless Gantrisin (acetyl)
Eye, Ear, Nose & Throat Infections	ophthalmic solution, 4%, ophthalmic ointment, 4%, ear solution, 4%, and nasal solution, 4%
Obstetrics & Gynecology	vaginal cream, 10%, in white vanishing cream base
Outpatient Clinic	tablets, 0.5 Gm each

Gantrisin®—brand of sulfisoxazole
Gantrisin® (acetyl)—brand of acetyl sulfisoxazole

Hoffmann - La Roche Inc • Roche Park • Nutley 10 • N. J.

editorial notes . . .

—about this issue

Most of this issue of HOSPITALS is devoted to a broad treatment of the subject of planning and construction. Planning, of course, is far more basic than a set of blue prints. It is the determination of needs and then the conception of a program, both in functions and in building, to meet those needs.

Today's trustee and administrator are more than stewards of an institution meeting current requirements for hospital care. They also have the responsibility to share in the planning for tomorrow. We hope that this issue will prove of value, not only for present problems but also as a guide to thinking about how we can help chart the future of hospital care.

—adding insults to injury

In 1951, the Congress raised postal rates but exempted certain charitable and philanthropic organizations from the increases on second and third class mail.

The standard test for giving special privileges, such as tax exemption, to charitable and philanthropic organizations has been that no part of the organization's net earnings inure to the benefit of any private shareholder or individual.

Judged by this traditional criterion, the nation's nonprofit hospitals were clearly entitled to the exemption provided by the Congress in the postal rate legislation. Furthermore, Congress and the executive branch have constantly recognized the special status of nonprofit hospitals.

But the Post Office department ruled otherwise. By administrative fiat, the postal authorities ruled that hospitals which charge patients who are financially able to pay are not charitable and philanthropic within the meaning of the postal laws, despite the fact that service may be rendered to some patients without charge.

A hearing was sought on this ruling, which on its face was contrary to long-established custom. The post office department officials recounted at the hearing that they had to pay their bills and that they "could see nothing charitable about nonprofit hospitals."

As the American Hospital Association has just informed Postmaster General Arthur Summerfield, such a stand is "based on illogical reasoning and lack of understanding of the historical development of hospitals of today. There appeared to be little understanding (at the hearing) of the fact that the very foundation upon which a charitable organization is able to exist and render public service is the requirement of partial or full payment from those who are financially able to pay."

It is our view that the proper criteria which must be met by charitable organizations to merit special privileges are (1) the rendering of a recognized public service and (2) the rendering of that service on a nonprofit basis. Obviously, nonprofit hospitals meet those basic criteria. A contrary ruling, such as that handed down, could by extension cloud the nonprofit status of universities because they charge tuition and even perhaps of churches because they take up collections.

The issue is important both as a matter of principle and as a matter of fact. Hospitals, besides being proud of their nonprofit prerogatives, use a good deal of second class and third class mail. The rate increase would be an even greater burden on hard-pressed budgets if the administration wins its current fight for even higher rates.

A suit has been brought in an attempt to obtain for nonprofit hospitals treatment equal to that given to other charitable groups. However, it may be some time before the courts finally rule on it.

Meanwhile, the Post Office Department has issued a new postal manual which aggravates the situation caused by the ruling against hospitals. Bulk mailings must no longer carry the legend "Section 34.66" or "Section 34.65(e)" as previously done. Organizations which qualify for exemption from the increase in rates must print the words "nonprofit organization" on the bulk mailing envelopes. All others—and this now includes nonprofit hospitals—must print the words "bulk rate."

Apparently, in the eyes of the Post Of-

fice Department, nonprofit hospitals aren't nonprofit organizations. This is a totally illogical position. A strong protest has been lodged with Postmaster General Summerfield and the Association will press its efforts to remove this unconscionable discrimination against nonprofit hospitals.

—the AHA and legislation

No one can quarrel with the opening statement of President Eisenhower's special message on health to the 84th Congress:

"Because the strength of our nation is in its people, their good health is a proper national concern; healthy Americans live more rewarding, more productive and happier lives."

There can be little disagreement with his outline of the problem areas: meeting the costs of medical care; constructing or rehabilitating the facilities for providing that care, and shortages in the trained personnel to study, prevent, treat and control disease.

Disagreement may come over the proposed methods. Considered judgment on the methods suggested either by the Administration or by the Democratic party cannot be rendered by the AHA until the specific measures are available for study.

At its recent meeting in Chicago, the Board of Trustees endorsed certain legislative proposals in principle but withheld endorsement or opposition on specific bills until the bills have been submitted and analyzed.

The Board endorsed:

Aggressive support for appropriate legislation in the field of mental health.

Increased aid for the medical care of the indigents as long as the aid was provided in a method compatible with AHA policy. The Association insists that any Federal aid in the health field (the only field in which the AHA is concerned) provide for maximum local administration and local control.

Aid for the training of certain ancillary personnel for patient care.

The Board took a stand in opposition to Federal scholarships for undergraduate nurses but deferred a policy statement on the Eisenhower proposal for scholarships for graduate nurses.

No position was taken on Federal health reinsurance pending study of the bill.

It is unwise for the Association to act hastily in such an important area as Federal legislation. It would be equally unwise to act so slowly that the AHA's influence would be lost. In the next few months, there is going to be an acute need for prompt AHA action in Washington.

The Board, therefore, has appointed a special committee of Trustees to consider Association position on legislation as these major legislative questions arise.

—the institute concept

We have been talking less of late of the Institute of Hospital Affairs. We feel that some comment might be in order lest this be construed to mean that the bold concept of the Institute as a gathering place for research and educational activities in the hospital field has been abandoned. Far from it.

The expanded program of the Association, its new building and the gathering together under one roof of organizations allied to improve patient care will bring the Institute concept to reality.

The foundation for the Institute idea is to be found in the activities of the various councils of the AHA. As additional funds become available because of the expanding programs, these council programs will grow in scope and increasing emphasis can be placed on research into hospital problems.

Even today, with our limited budget, work is being done in such fields as hospital law, hospital insurance, radioisotopes, mental hospitals. We appreciate that we are only scratching the surface. But once the total AHA program is underway and once we are housed properly and in close relationship to our allied organizations, the concept of the Institute of Hospital Affairs will have been realized.

—about fable and fact

An item by R. L. Duffus in a recent issue of Nation's Business intrigued us. Here it is:

"Only two of the 90 policemen of Wheeling, W. Va., when examined not long ago, were found to have flat feet. I wouldn't be surprised if the same were true elsewhere; and I think this proves that a lot of unkind things that are said about people aren't necessarily so."

We think it applies to hospitals, too.

all of these questions. There are, adjusted to the resources, without only those features which differ

HOSPITALS planning

the essential first steps

E. TODD WHEELER

WHEN THE NEED for hospital beds or related services becomes so acute that it can no longer be ignored, someone usually starts planning. In truth, the planning should be started long before such time, or better yet, should be done as a continuing process.

The concept of continuity in planning is far from new, but human nature seems to make us all put off planning until we are forced to it. Far better that needs be reviewed periodically and plans made accordingly without the pressures of urgency. A continuing or long-range plan need not be elaborate but, if it reflects the hospital's needs and the probable resources, it can serve as a most useful tool. This philosophy presumes continuity of growth and adaptation to changing needs; and thus, in itself, it fosters a healthy attitude toward the future. It is surprising how often the existence of a plan will call forth support not suspected, and how often lack of one wastes opportunities.

The planning process is so elementary as to seem obvious, yet too often it is not fully understood by all concerned. First determine the needs, next figure out a way to meet them, then do something about it. The process can be described more fully and technically, but the essentials do not vary. It must be generally understood that the early steps in planning, though less involved than the later technical ones, are actually of greater consequence. At that stage the essentials of the project are established, and from these essentials are derived the ultimate character and extent of the development. Care in determining functional requirements will pay dividends many times over. For this process, those who are closest to community needs should participate in the planning, though they may need assistance from others with wider experience or special training in planning. Knowledge of trends and the reasons for them, vision and objective thinking are of utmost importance.

Mr. Wheeler, a consulting architect, is a member of the Committee to Write a Manual for the American Hospital Association on the Development of Architectural Programs.

BASIC QUESTIONS

The best plan springs from an established need and reasonably adequate resources. Inevitably many questions arise in the early thinking:

•-How do I get started on needed improvements?

•-My board is willing to try to raise funds for more beds, but what we really need most is a new kitchen. How can I convince the board of this?

•-Should we tear down our old buildings or modernize them?

•-How can I make improvements without interrupting operations?

•-How do I get an architect who knows something about planning hospitals?

•-Why do architects' fees vary so much?

•-How much should we spend on a new power plant?

•-What good will a consultant do, and how do we find one, anyway?

•-Who should pay for the consultant if we have one?

•-How long should it take to plan and construct the hospital?

•-Does the architect actually build the hospital? If not, what does he do for his fee?

•-Suppose we haven't enough money to do all we need. How can we be sure that what we do now will not have to be redone later?

•-How can I know in advance what equipment we will need, and how can I be sure it will fit into the rooms we plan?

Such questions, perhaps, seem elementary, but they are real questions raised on many projects. No one person knows the answers to

own experience or can seek out-

schedule of responsibilities

all of these questions. There are, however, ways to get the proper persons together and to find many of the answers. Technical aid will help translate the known needs and resources into some effective plan of action. In the planning process, the administrator and his board play an equal part with the professional planners and builders. The basic decisions that must be made, in defining the functional programs which the architect is to translate into designs and structures, are primarily the responsibility of the building committee or board.

SURVEY OF NEEDS

On any hospital project, whether new or existing, a survey of the functional needs is essential. The administrator and his department heads can go far in determining these by recording all the observed needs of the hospital, not only in terms of hospital beds but also in the adjunct diagnostic and therapeutic services and other hospital departments. In many cases, however, the determination of needs is a more complex process, calling for consideration of facilities in other hospitals in the community and many other factors about the future of the community. For such a study the aid of outsiders will be needed.

In some places, government agencies in the field of health and welfare can give aid. Often a qualified hospital consultant can serve by making the community survey with the aid of the local person's knowledge of factors affecting the local situation. The process will lead to a judgment to be made by the hospital board, not only as to the need but also as to the potential resources for meeting it. Usually the needs far exceed the resources, and the planning must be in stages as funds permit.

It is in such a case that the value of a long-range plan is especially felt. The long-range plan will show, in order of urgency, the many steps by which the ultimate goal can be achieved. Sometimes plans are developed that are rigid and must be carried out all or none. Too often these are the ones that do not get completed at all. Flexibility is an essential of any plan to permit the needs to be adjusted to the resources, without losing sight of the needs which must be left unmet. This is a value of master planning.

Once a goal is set it should be expressed in specific terms. This is called writing the functional program. The number and kinds of beds are listed, the kind and size of x-ray units, the extent of laboratory services, of physical and occupational therapy, of outpatient services if any, the requirements for staff housing, the need for professional or subprofessional training and any other known requirements. From such requirements the architect can estimate the size and possible shape of the building and make sufficient schematic drawings to permit a preliminary cost estimate.

If such estimate is within reach of the budget, the preparation of the detailed building program can be initiated. The architect and the administrator, with the aid of the consultant, list all spaces and equipment thought to be needed, arranging the information in an orderly fashion by departments and including all data available. The building program serves as a guide to the architect throughout the planning; and in the early stages, particularly, it aids the administrator by serving as a check list to make sure no elements are omitted. Valuable reference material on programming is available from the American Hospital Association and the United States Public Health Service, as well as in the literature on hospital planning. The importance of the functional program and the detailed building program which stems from it cannot be overemphasized.

One other category of essential information relates to the planning, namely the pertinent facts about the hospital's anticipated organization and operation. A knowledge of the number of personnel is needed to plan the staff locker rooms and dining rooms, the administrative offices, the shops and many other working areas throughout the hospital. Working knowledge of hospital operations is needed to plan any of the departments, especially those involved in the handling of patients and in the processing of food or goods.

Often it is sufficient to describe only those features which differ from the standard, but it helps administrator as well as architect to think through and set down in writing the particular functions to be performed in each department. This is especially true of food service, emergency service, central sterile supply, pharmacy, central general stores and the outpatient services. In these departments, the pattern of operation may vary considerably from that thought to be the standard. Related to this, also, is the recording of any special equipment needed to operate the hospital.

PRELIMINARY PLANS

Armed with a complete program and with a beginning knowledge of the special problems of organization and operation, the architect is then ready to prepare preliminary plans. Considerations of the building site, the location and size of the new building and the stages of construction will enter early, but the first and most important area of prime study will be the nursing units themselves.

Following this, the other departments are developed in proper relation to the beds; and a shape for the building may be evolved. Only then should there be any concern over whether the shape is T, X, U or what have you. The shape of the plan is derivative, not fundamental. What is more important is to test the plans by studying the flow of patients and other persons, and of food, linen, medical records, drugs and other supplies in the operation of the hospital. In this process will be revealed weaknesses or strengths of the planning, which will guide those involved in the planning towards a workable solution.

RESPONSIBILITIES

Mention has been made of the board, the administrator and his department heads, the consultant and the architect. All of them have important parts to play in planning, especially if care is given to the functional program and the detailed building program. No one person knows all the answers to questions that arise in planning a hospital, but the individuals who make up the planning team can usually find the answers in their

own experience or can seek outside counsel if necessary. Together, they are responsible for designing and inspecting the construction of the hospital, for equipping it and, in some measure, are responsible for staffing its initial operation.

The responsibilities of members of the planning team vary. In initial stages they rest most heavily upon the administrator and the consultant. For fund raising the board is the leader—for detailed planning and construction, the architect. The builder is a member of the working group in the later stages and occasionally takes part in some of the planning and cost estimating. Perhaps the accompanying schedule of the various stages and responsibilities will help clarify this.

It will be seen from this table that the administrator has the most comprehensive responsibility. Since he usually has to continue to operate the hospital while the planning and construction are in process, the major responsibility is assigned to the architect from the time the needs are established and the functional program agreed upon. The architect should be encouraged to take the lead thereafter.

The role of the consultant varies. In many cases the architect and administrator have sufficient knowledge and time to carry the full responsibility, but often the consultant is able to assume responsibilities for which his special knowledge qualifies him. The accompanying schedule indicates that these responsibilities come most often in the early stages of planning or at the end during procurement of equipment.

Questions often arise as to who should be expected to pay the consultant. The answer depends upon the kind and extent of the work he is asked to do. Usually this is work the owner or his agent, the administrator, must undertake; and in such case the consultant is paid by the owner. If the consultant is asked to do work which is the architect's responsibility, then he should be paid by the architect. In such case the architect would, of course, have a part in selecting him and in agreeing to use such services. No general rule for this

schedule of responsibilities

ACTION	RESPONSIBILITY	ASSIST OR SUPERVISE
1. programming and planning		
A. Initiate the project	Trustees (Owner)	Administrator
B. Select planning team	Trustees	Administrator Architect Consultant
C. Establish needs Community survey	Trustees Consultant	Administrator and Medical Staff
D. Functional program	Consultant Trustees	Administrator Architect
E. Budget	Trustees	Consultant Architect Administrator
F. Building program	Architect	Consultant Administrator and Department Heads
G. Preliminary plans	Architect	Consultant Administrator and Department Heads Trustees
H. Working drawings and specifications	Architect	Administrator Consultant Interior designer
I. Financing	Trustees	Administrator Consultant Fund raisers Attorney
2. site selection and development		
A. Select a site	Trustees	Consultant Architect Administrator
B. Purchase the land	Trustees	Attorney Real estate agent
C. Plan site developments	Architect	Landscape architect Civil engineer
D. Undertake improvements	Contractor	Architect Landscape architect Civil engineer
3. construction		
A. Take bids and award contracts	Trustees Architect	Administrator Consultant
B. Construct building	Contractor	Subcontractors
C. Supervise construction	Architect	Administrator Owner's clerk of the works Interior designer
D. Make payments	Trustees	Architect Administrator
E. Make final inspection, collect contractors' guarantees, operating instructions and other records for owner, turn building over to owner for use.	Architect	Administrator
4. equipment		
A. Equipment lists	Administrator	Consultant Architect
B. Specifications	Purchasing agent	Administrator Consultant Architect
C. Special designs and furnishings	Interior designer	Administrator Consultant Architect
D. Purchasing	Purchasing agent	Administrator Consultant Interior designer
E. Installation	Equipment contractors	Purchasing agent Administrator Interior designer
5. operations		
A. Operating policies	Trustees Administrator	Consultant
B. Personnel lists	Administrator	Consultant
C. Operating budget	Administrator	Consultant Trustees
D. Financing	Trustees	Administrator
E. Recruitment	Administrator	Personnel officer
F. Operation	Administrator	Staff

can be laid down except that the consultant generally fills in where other members of the planning group need help.

CONCLUSION

The end point of planning is two-fold—first, to arrive at an understanding of both immediate and future needs and to judge the degree of their immediacy; and second, to produce the drawings, specifications and contracts which form the technical tools through which the needed buildings and equipment can be procured. If the latter process can be thought of as but one step in many to be taken in carrying out a long-range plan for growth, there will be a better understanding that planning is both an immediate and a longterm process. With such understanding comes the motive for continuing to plan for growth or changing requirements as long as the hospital and the community exist. ■

meeting changing needs

NEW DISCOVERIES AND NEW techniques in the health field bring with them changes in the type and character of care required by the sick. Early ambulation, shorter stay, virtual elimination of certain diseases, emphasis on outpatient care and progress in rehabilitation have made their imprint on hospital design. Medical advances have given individuals the gift of longer life. Yet a concomitant of longer life is a longer period in which the individual is subject to chronic illness.

These and other factors make planning for the care of the sick and for the facilities in which care is rendered a dynamic process. Many groups have recognized these trends and have adapted their planning to meet them—and Congress, too, has expressed its awareness in legislation.

In the Hospital Survey and Construction Act of 1948, provision was made for grants to stimulate construction of public and other nonprofit hospitals and related health facilities in areas where they were needed most.

Speaking at the American Hospital Association's annual convention in Chicago last year, Senator Lister Hill (D., Ala.), joint author of the Hill-Burton program, reviewed some of the important principles that were built into the program. "The principles," he said, "have had much to do with the program's success and can well serve as a basis for the expenditure of federal funds for meeting public needs in other fields." Some of the principles he enumerated were:

- A demonstrated need, substantiated by study and survey.
- Local decision of greatest need and priority for expenditure of funds.
- Maximum administrative authority given to the states.
- Joint financing by all concerned.
- Requirement that there be local responsibility for the operation of any facility.
- A federal council to review administrative procedures to insure that the federal administrator does not act in an arbitary manner.
- A formula for the division of funds which recognizes the relative needs of different sections of the country and their ability to meet these needs.

Amendments to the Hospital Survey and Construction Act, made last year, have broadened the original program to encourage construction to meet changing health needs. The four classes of projects included are: diagnostic centers or diagnostic and treatment centers, rehabilitation facilities, chronic disease hospitals and nursing homes.

Rehabilitation facilities and diagnostic or treatment facilities, when these units are part of a hospital, and chronic disease hospitals were included under the basic program. Proponents of the amendments felt that earmarking funds specifically for each of the four categories would be a stimulus to their construction. On the other hand, it was pointed out by representatives of the American Hospital Association during testimony on the new legislation that one of the deterrents to construction of these facilities had been the basic problem of providing funds to operate the facilities after they were completed. Testimony further stressed that this problem still remained under the proposed extension, later enacted into law, of the Hill-Burton program.

The Hill-Burton categories have not yet been subjected to the test of time as has the original program —a program which it is agreed has made a vital contribution to meeting the health needs of the nation and has stimulated hospital planning and design.

In both the original Act and the amendments, there is a clearly stipulated prerequisite to receiving grants to assist in meeting construction costs. Orderly planning is required. A survey of existing facilities must be made so that each state can develop a documented plan and present a coördinated program for the construction of facilities.

The survey and planning process has brought planning teams to-

"... an important step forward in stimulating a much needed increase in facilities for rehabilitation services."—Howard A. Rusk, M.D.

REHABILITATION FACILITIES

"... it is important that nursing homes be a part of the total coördinated pattern of community medical care."—James P. Dixon, M.D.

NURSING HOMES

"The trend in modern medicine ... indicates a need for diagnostic and treatment centers."—John W. Cronin, M.D.

DIAGNOSTIC OR TREATMENT CENTERS

"Hospital planners have a responsibility to ... the chronically ill and the infirm aged."
—Marcus D. Kogel, M.D.

CHRONIC DISEASE HOSPITALS

"The more than 700,000 beds in state, federal and private mental hospitals do not meet present-day needs."—Charles K. Bush, M.D.

MENTAL HOSPITALS

gether resulting in the exchange of information. Technical recommendations from the architectural section of the Division of Hospital Facilities and a series of conferences, seminars and institutes have helped in disseminating information to those concerned with hospital design. Participating and cooperating in these educational endeavors were the American Institute of Architects, the American Association of Hospital Consultants, the American Hospital Association and state and regional planning agencies. This same type of coördination is specified for the new categories, and since relatively little construction has been done in these areas, there is a need for a careful, studied approach.

Following are statements from authorities in the health field outlining need in areas of the total health picture. In this picture the importance of the amendments to the Hill-Burton program has been recognized. The thread woven through all the statements is that there is a need for our best thinking and planning to do the most for the health needs of our nation with the resources presently available. ■

HOWARD A. RUSK, M.D.

THE 20,000,000 persons who receive care in our nation's hospitals each year are provided the world's finest medical and hospital care. Many, however, are discharged with physical disabilities which prevent them from returning to productive roles in society. Others remain in medical and custodial institutions because of the

Dr. Rusk is professor and chairman, Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City.

lack of rehabilitation facilities.

It is estimated conservatively that there are 2,000,000 physically handicapped persons in the nation who could profit from rehabilitation. An additional 250,000 of newly disabled persons join their ranks each year. Experience has shown that comprehensive, integrated rehabilitation services "pay off" medically, socially and economically. Tax consumers are made into tax payers, scarce medical personnel are saved, hospital beds needed for acute patients can be released and, most important, the disabled can return to lives of dignity and productivity.

In providing grants-in-aid for "rehabilitation facilities" under Public Law 482, the federal government has taken an important step forward in stimulating a much-needed increase in facilities for rehabilitation services. In its regulations governing the administration of these grants, the Public Health Service has wisely stated that special consideration shall be given to: (1) projects located in medical centers, medical schools or universities with medical schools or medical centers; and (2) projects providing a multiple disability service as distinguished from those providing a single disability service.

It will be many years before there will be sufficient facilities and trained personnel to bring rehabilitation services to all those who can thereby benefit. Making federal grants-in-aid available for expanding rehabilitation facilities, however, is a heartening and forward-looking step in the right direction. ■

JAMES P. DIXON, M.D.

THE NEED for nonhospital type institutional facilities has evolved from progress made in medicine and advances in the social sciences during the past several decades. Increased interest in social security has stimulated development of the nursing home, a facility of this type. Nursing homes provide care for persons who require special services that preclude living in their own homes or outside an institution.

The need for the nursing home has been clearly established. This need relates to the process of aging and the nature of a community's pattern of medical and custodial facilities. Though we know much too little about the staffing, about the services rendered or the quality or quantity of care provided, it is important that nursing homes be a part of the total coördinated pattern of community medical care.

One possible method of coördination in many communities is establishment of nursing homes as adjunct facilities to general hospitals. Such a program allows transfer of the patient from the general hospital to nursing home care when his condition no longer requires hospital facilities and, maybe, his return to the hospital if his condition later warrants. This provides for effective maintenance of standards and utilization of medical staff, personnel and facilities. This permits a program based on the needs of the patient.

The new Hill-Burton regulations define the nursing home as "a facility which is operated in connection with a hospital or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in the state . . ." This definition permits a realistic approach towards integration of facilities.

Boards of trustees, directors and administrators of hospitals would do well to evaluate and take advantage of the new services and resources under the new Hill-Burton program whenever possible, and so to extend the usefulness of the hospital as a community health institution. ■

JOHN W. CRONIN, M.D.

THE NECESSITY FOR early diagnosis and treatment integrated with programs of prevention and health education, in maintaining an optimum level of health for the individual, is recognized in Public Law 482, 83rd Congress. Provisions of the Act relating to diagnostic and treatment centers for ambulatory patients, and to diagnostic centers for these patients, are directed at earlier diagnosis and treatment for more people.

The trend in modern medicine toward more ambulatory care, combined with more complicated instruments of precision, indicates a need for such centers.

The diagnostic and treatment center is defined as "a facility providing community service for the diagnosis and treatment of ambulatory patients, which is operated in connection with a hospital, or in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the state, or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the state. This includes outpatient departments and clinics of public or nonprofit hospitals. The applicant must be either (1) a state, political subdivision, or public agency, or (2) a corporation or an association which owns and operates a nonprofit hospital."

The type of facility contemplated would make it possible for medical and paramedical personnel to work together as a team. Many of the centers will be component parts of hospitals; nevertheless, it is possible for communities in which maintenance of a hospital is not feasible to build modern diagnostic and treatment centers.

Each Hill-Burton state agency is urged to request the coöperation of the state, county and city medical and dental societies in determining the extent of diagnostic and treatment services available, as well as the need for additional services throughout the state. The state agency is also urged to invite the coöperation of such voluntary and governmental agencies as those concerned with cancer, heart disease, tuberculosis, mental health and crippled children, among others.

Upon completion of the respective state surveys and the development of the state plans, there will be available for the first time an orderly program within each state relating to the provision of diagnostic and treatment services for ambulatory patients. ■

Dr. Dixon is health commissioner of the City of Philadelphia.

Dr. Cronin is chief of the Division of Hospital Facilities, Public Health Service, Department of Health, Education and Welfare, Washington, D. C.

MARCUS D. KOGEL, M.D.

THE TEMPO of our present-day medical progress has thrown the spotlight on the needs of the aged and chronically sick, on rehabilitative medicine, on outpatient services, on home care and nursing homes. Hospital planners have a responsibility to future generations in regard to the facilities being provided for the chronically ill and the infirm aged.

The danger is that these unfortunates may come to be considered as second-class medical citizens and removed from the common stream of medical activity. The chronically ill require the same fidelity of care as the acutely sick. The tendency is much too prevalent to house them in outmoded accommodations, to be cared for by underprivileged physicians. The problems of the chronically ill and infirm aged are sufficiently varied to require the whole spectrum of medical services, which can be furnished properly only in a general hospital setting.

The organization of the general hospital of the future would be incomplete if it did not provide for its services to flow to the homes of patients through home care programs, if there were no provisions for a good outpatient department, if it were not the center for rehabilitative medicine, if it were not actively concerned with every available resource for care of the chronically ill, including even foster home care and nursing home care.

The outpatient department is particularly important as the link between the hospital and the community. The concept that such a facility is useful only for the indigent is as archaic as the majority of the existing outpatient services. The medical college finds the outpatient department a rich resource for clinical teaching material. To the practicing physician, it is a referral source for patients where there is a concentration of complex and costly diagnostic and treatment facilities and professional skills indispensable for the practice of good medicine in this fast-moving age.

Rehabilitation services help reduce the damage of illness and make it possible for the disabled to live and to work up to the hilt of their capabilities. This is a phase of medicine that will gain impetus as more trained personnel and facilities become available.

The federal government is giving this vital activity a real shot in the arm through an expanded vocational rehabilitation program and expanded Hill-Burton program. The enlarged Hill-Burton program also provides federal grants to aid in building and equipping diagnostic and treatment centers, chronic disease hospitals and nursing homes. These are all areas of critical importance, and they need our best thinking in planning for them. ■

Dr. Kogel is dean of the Albert Einstein College of Medicine, Yeshiva University, New York City.

CHARLES K. BUSH, M.D.

THE MAGNITUDE of the problem —care of the mentally ill—has caused it to be labeled America's number one health problem. This is justified by the fact that, at any particular time, there are as many patients occupying beds in public and private mental hospitals as there are patients in all other types of hospitals together. The more than 700,000 beds in state, federal and private mental hospitals do not meet present-day needs. One-third of these beds are in antiquated firetraps which should be replaced, and an additional 500,000 beds should be provided in the next ten years.

New concepts in psychiatry stress the importance of early and intensive treatment in order to avoid longer and most costly custodial care. Prevention, early recognition and early treatment will result in either a cure or the arrest of the mental illness to a point which will not require hospitalization. To set up such a program will require outpatient clinics in the community and an educational program to teach people to use the clinic facilities before mental illness reaches a point where hospitalization is necessary.

With expanded treatment programs in all mental hospitals, more and more patients are being returned to a useful life in the community; and this is economically sound.

Buildings alone are not sufficient. The buildings must be adequately staffed with well-trained people in order for the patient to get the maximum benefit from either inpatient or outpatient care. The whole system of care of the mentally ill is wrong in the light of present knowledge, in that mental hospitals are frequently located in regions isolated from medical and cultural centers where it is hard to recruit personnel, hard for relatives to visit and easy for everyone to forget.

These things can be overcome only by education—education of the public to accept mental illness as a sickness the same as they have tuberculosis and cancer; education of the legislators and state governments to make them realize that money spent in prevention and early treatment would be only a fraction of what would be spent later for custodial care; education of the public and state governments that institutions should be built close enough to urban medical centers so that there can be a closer relationship between professional people at the hospital and at the community clinics, for medical training and research.

I believe that these ideas are basic to any mental health program.

There are between 300 and 400 general hospitals that now have inpatient psychiatric units, and many of these also have outpatient psychiatric clinics. This number should be greatly expanded in the next few years. Many more people would accept hospitalization in a general hospital than would accept it in a public or private mental hospital, because people still attach a stigma to the mental hospital.

Perhaps more general hospital administrators should visit mental hospitals. They would see for themselves that 95 per cent of all admissions could be cared for in the general hospital setting. ■

Dr. Bush is director of the Mental Hospital Service Architectural Study Project of the American Psychiatric Association, Washington, D. C., which now is undertaking basic research on mental patient admissions as a prelude to proper design of psychiatric units. These remarks are abstracted from a paper delivered by the author to the 1954 annual convention of the American Hospital Association in Chicago last September.

building

a medical center emerges from a community survey

"If Hunterdon were to build just another hospital, I would be lukewarm to the proposition, but if this hospital is projected in terms of a progressive institution with a university affiliation, a model of its kind, aimed to bring what is best in medicine to the residents of a rural area, and has associated with it an active, full-fledged health center and a good follow-through social service, I would be strongly for it. The opportunity is here, and there is unquestionably enough civic pride and business enterprise in this community to bring the plan for a hospital and health center to a successful consummation."—E. H. L. CORWIN, Ph.D., Report, January 1948.

IN A FEW MONTHS, Hunterdon County's famous hillside medical center will be entering its third year of operation.

This is the health center that sprang into being only after an extensive community survey to explore resources and needs of a largely rural population. It was designed to answer these needs with a detailed and highly flexible plant and program.

Hunterdon was selected, moreover, by New York University-Bellevue Medical Center for a new community extension of medical education. It drew upon the Commonwealth and Kress funds for studies in rural health and preventive medicine. Just completed has been an intensive three-year survey of more than 4,200 local families for the Commission on Chronic Illness—objectives to determine needs, the extent of chronic illness in rural people and the extent to which it could have been prevented.

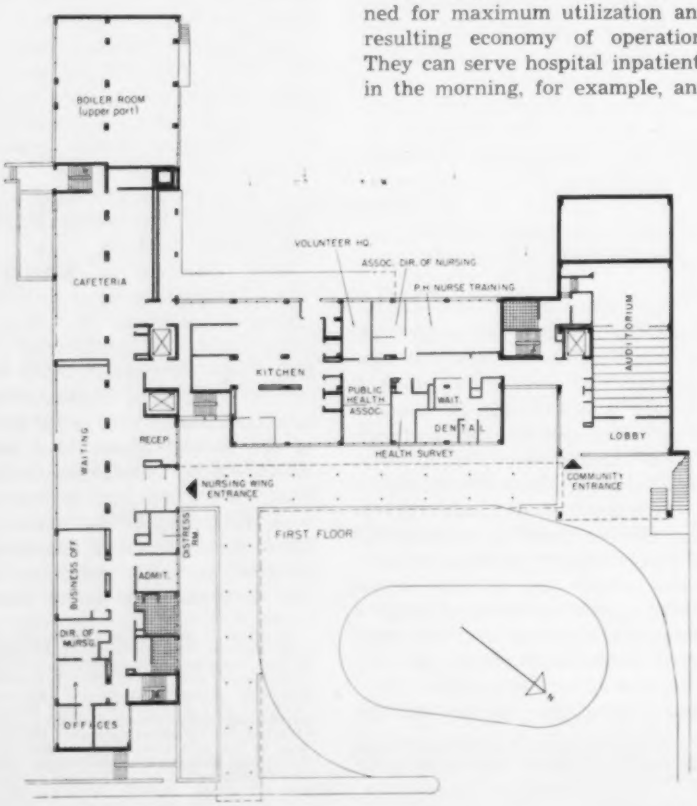
Hunterdon has, perhaps, one of the most widely publicized hospital plants of our time. It is handsome, modern, functional — the structural realization of a multi-purpose health center.

One side—the patients' side facing south—is almost entirely of glass. Floor-to-ceiling windows face out over the gentle, rolling hills of western New Jersey. This is the conventional general hospital, a five-story wing containing Hunterdon's 120 beds, its 22 bassinets, house staff quarters and the other things that go to make up a good general hospital.

To the north is a smaller wing for ambulatory patients, the center for community health activities. The community entrance, direct to the auditorium and public health offices, opens from the ground floor. The second floor is a diagnostic center—its offices and U of examination rooms are reached through a separate entrance from a special parking area. The third floor has the department of physical medicine, locker space and offices.

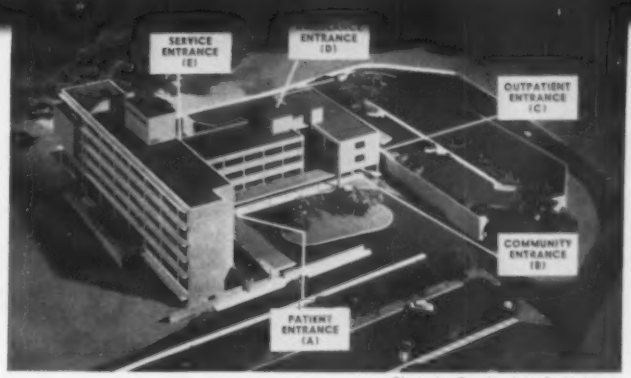
Binding these two wings horizontally—and functionally inseparable from either—is a three-story link of adjunct services. Here are the laboratories, the x-ray and food preparation areas, the pharmacy and the blood bank. Activities are carefully grouped: for instance, blood bank, pathology-sterile supply, anesthesiology, surgery and surgical beds lie within 100 feet.

These adjunct services are planned for maximum utilization and resulting economy of operation. They can serve hospital inpatients in the morning, for example, and



HUNTERDON MEDICAL CENTER

location:	Flemington, N. J.
beds:	120
total cost:	$2,220,833 (including group I equipment)
cost per sq. ft.:	$19.50
director:	Ray E. Trussell, M.D.
architect:	Vincent G. Kling, Philadelphia
associate:	William W. Eshbach, Philadelphia
medical consultant:	Donald C. Smelzer, M.D., Lancaster, Pa.
contractor:	Nason and Cullen, Philadelphia
opened:	July 1953



—Photo by Cortlandt V. D. Hubbard

MODEL demonstrates segregation of various entrances. Under covered canopy are ground-floor entrances to hospital (a) and community clinic (b). Ambulant patients (c) and emergency patients (d) enter on second floor level. Service entrance (e) to basement is at rear. Note separate parking for clinic patients. Since construction of the model, changes have been made in parking arrangement. Provision is made here for terrace, left, as yet unbuilt.

outpatients from the diagnostic center in the afternoon. Some 25 to 30 well persons use the services nightly as part of the screening program, now carried on as a community service.

In this middle wing, also, are offices and working spaces which can be adapted to a future county board of health. The Public Health Association (TB, cancer and crippled children's work) already is lodged here, as well as an active dental program.

One of the most heartening things about the Hunterdon Medical Center, of course, is the way it came into being. Once conceived, it was swept to completion on a tremendous wave of popular enthusiasm. But before the first sketches were presented or the first specifications drawn, a detailed community survey was run on Hunterdon's resources and its potential.

Author of this survey was the late E. H. L. Corwin, for nearly 40 years executive secretary of the Committee on Public Health Relations of the New York Academy of Medicine. He pinpointed strengths and weaknesses—from these, he outlined the backbone plan for a hospital. Corwin spoke not in terms of a 50-bed outland institution but of a comprehensive rural health center—one that would bring to Hunterdon County the best medical thinking for the promotion of mental health, as well as the best diagnostic and treatment facilities.

Corwin had the weight of his community survey behind him. Hunterdon soon realized this plan was so special it would be a tragedy if it couldn't come to pass.

The 1949 fund drive that followed brought fantastic response. In all, a million dollars was raised. In the end, another $600,000 was there—and so was a deep-rooted and lasting recognition of the community's moral and financial responsibility for the Medical Center.

The rest is history. A crisis arose in 1950, when inflation left the project some $900,000 behind the best bid. Hill-Burton priorities couldn't be held indefinitely. Rising costs seemed to be pricing the Center right out of existence.

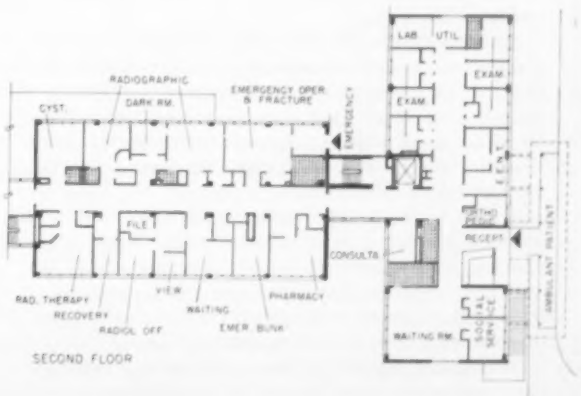
As alternatives to more fund-raising, the trustees and program leaders offered two choices—one, to abandon the idea entirely with trustees to absorb costs, or two, to forget the concept of a medical center and draw up plans for a small rural hospital. The county accepted no compromise to the original plan. Then the Commonwealth Fund chipped in with an exceptional brick and mortar grant of $250,000 contingent on the balance being raised. The project went ahead to completion.

In July 1953—one year and eight months after ground had been broken—Hunterdon Medical Center opened its doors. Lost along the way had been a few details, such as a ground-floor bypass around the kitchen, the acoustical ceilings, the terrace on the south wall, but these were minor.

Flexibility and adaptability of the Medical Center already have been tested. Modifications imposed by an expanded staff, for instance, were made with little difficulty. Unused space reserved for a county health department was designated for special projects. A unit record system is being adopted to identify patients both as individuals and by family, and coördination of these records into a central location is underway.

Needed space is available, moreover, as the Center moves toward its long-range goals—the direction of school and preschool health, premarital counselling, accident prevention, rehabilitation and mental health. Already plotted is the tentative location for a nursing home adjacent to the Center—if and when.

Today, questions are being asked of the Hunterdon Medical Center. Is it truly a forecast of future rural



health? What is Hunterdon doing, and how well?

Some observers are reserving judgment pending financial success of the project. Others express concern about the Center's full-time specialist plan, or that the Center will attract undue patients from adjoining areas and thus strain facilities. The suggestion has been made that Hunterdon developed in a unique rural area —would the Medical Center have been possible elsewhere, under other and perhaps more complicated conditions?

Answers to these questions—and a real evaluation of the whole concept—still lie ahead. The present path, however, is clear. Hunterdon developed only in response to community needs and only after a detailed survey had been made to isolate these needs. This is the essence of good planning—a unique hospital designed specifically for a known situation. ■

"Two projects rank high on the list of our objectives. The first is integration of public health nurses under central administration and supervision—with advantages of followup after screening and easy transfer of patients from hospital status to home care and back, as required. Second, I see nonprofit nursing homes integrated with the Medical Center, the first to be located adjacent to the Center itself. This would augment services available to these patients and allow supervision over the quality of care given. It would help in the organization of volunteer services so as better to assist patients and give them the recognition they deserve."—RAY E. TRUSSELL, M.D., medical director, January 1955.

a plan in action

WHEN E. H. L. Corwin, Ph.D., launched his survey of Hunterdon County in 1947, he needed down-to-earth facts. He had to know, for example, the extent of health resources then available. He had to know if the situation could be expected to improve. Only through these facts, and analysis of the need, could Hunderdon determine whether or not it needed a hospital, and if so, what kind and of what size.

His report of January 1948 outlined the resources and weaknesses he had uncovered. It pointed to conditions that could be vastly improved, but it pointed also to a great potential. Corwin envisioned a community hospital and health center that could relate the best practices of preventive and curative medicine, and toward that end he made his recommendations.

Changing times have worked some revision in the basic program, of course, but the story of today's Hunterdon Medical Center is perhaps best told in the success with which the Corwin recommendations have been carried into action.

A detailed report follows on the survey findings and provisions of the Hunterdon program today.

the Corwin report

In 1943, Hunterdon County was some 80 per cent rural, with a population of 34,245. Flemington, county seat and second-largest town, had less than 4,000 persons. Limited industry spelled a family income considerably under $4,000. By percentage of population, the county showed 5 per cent fewer persons in the productive 15-44 age bracket than state-wide averages, some 5 per cent more over age 65.

State estimates—on a very broad base—indicated more than 20 per cent of the county's population as suffering from permanent impairment or some sort of chronic disease.

(Today's census of 44,000 indicates greater industrial activity in the county, but basic conditions remain roughly the same.)

Hunterdon proved hospital-conscious to a surprising extent, considering the largely rural character of the county, the per family income and the fact that Hunterdon had no general hospital save a tiny proprietary institution in Glen Gardner. Eighty per cent of the children born then to county

TYPICAL patient room has two beds, excellent view of surrounding countryside. Hanging curtain is part of plan for flexibility.

DAYROOMS (at left in above photograph) have allowed expansion space for future needs in five-story hospital wing.

residents were hospital babies. Estimates suggested that some 3,000 Hunterdonites were hospitalized annually, some 8 per cent of the population.

The county was fortunate in having 32 general practitioners, more than half of whom had been graduated from medical schools in the past 25 years. Only five had hospital appointments, however, and only 13 of the remaining group had even courtesy privileges. There were no specialists of any sort in the county.

hospital for the community

"The hospital would create a desirable community resource around which many services in the public health field could be clustered . . . an outlet to civic activity and civic pride."

That was the way Corwin conceived the Medical Center, in a sense, as a demonstration project in rural health service—ultimately calling for fullest community participation. When Hunterdon residents had developed a working knowledge of the Center, they would assume active responsibility for its success.

Every effort has been made in this direction. Today, the typical patient has had contact with the Center long before he is admitted for medical or surgical service. He knows the staff and he knows the program.

He may have taken a popular course in weight control or attended a special class for expectant mothers and their husbands. He may have gone through the multiphasic screening program (4,246 have, to date) or—if he is a high school teacher—attended one of the Center's all-day seminars on the emotional problems of adolescence.

As the member of a local organization, he may have been present when his group met in the Center's 132-seat auditorium—in the first ten months alone, 50 such "outside" groups availed themselves of the opportunity. He may have attended a "town-hall style" question and answer session. In either event, he will have had lunch or supper in the Center's sparkling cafeteria and later had the benefit of the multiple screening tests.

All in all, nearly half the county's population has had some contact with the Center to date.

Three distinct community groups have helped to guide policy. A public health advisory committee, including representatives from every organization giving health and welfare services in the county, was very active before the Center opened. A community council of 165 members—drawn from all the county's 26 municipalities—meets periodically now as a policy sounding board: the council explains the Center's program to the people. A self-perpetuating lay board of 20 trustees, traditionally community leaders and men of action, represent a wide range of interests and vocations.

The medical program of the Center has been geared to the important role of the family doctor and integration of his work with that of the specialist group. The Medical Board includes general practitioners and specialists in even number.

Evidence of Hunterdon's great success in community participation is demonstrated by the volunteer response. Although the Center has no formal auxiliary organization, more than 300 workers put in some 40,000 hours during 1954. A group of volunteer corpsmen now is being organized for evening duties.

public health

At the time of the survey, Corwin reported public health facilities in the county as "antiquated." Township boards of health were autonomous. School health depended on local arrangements. The few existing public health clinics were sketchy in character and public health nursing wholly inadequate. No attempt had been made to unite townships in securing an active health administration.

THE SURVEY

●—Coördination of Services. Corwin saw the Center, in its final form, as a central public health laboratory and clinical site. The county health officer and hospital administrator, he said, might well be the same person.

THE RESULTS

Officials at the Medical Center are frank to admit least success in this area. Despite the inclusion of public health office facilities in the building (some of which are now used for various other purposes), county voters defeated, by 2 to 1, a 1952 effort to formalize county-wide public health administration. Neither a county health officer nor department has come into being. Local communities and townships remain autonomous.

●—School Health. Services in 55 grammar and six high schools were random. Health supervision rested upon local arrangements. High schools received slightly more attention than grammar schools—periodic tests for tuberculosis, for example.

Public health nurses have participated in the Center's inservice education program. The supervising nurse maintains her office there. Teachers have been screened through the clinic and participate in joint training projects with the Center. A pilot demonstration is underway at Quakertown School, Franklin Township, where the Center's pediatrician is school doctor.

●—Dental Health. State and local funds provided two dental clinics, one in Lambertville, one in Flemington. Only two of 16 practicing dentists in the county participated, however.

Projected now is participation of all county dentists in an oral and dental division at the Center, under direction of the chief of oral surgery at Bellevue General Hospital, New York. The dental clinic then existing in Flemington has moved into the Center on a coöperating program.

●—Public Health Nursing. At the time of the survey, Hunterdon County had nine public health nurses: on the basis of one nurse needed per 2,000 population for complete bedside nursing, the county required double that number.

Today there are 13 public health nurses in the county, almost enough for general needs but still nine short of the number required for home nursing. Ten of these nurses make visits. Despite continuation training at the Center, these nurses are not adequately equipped for home care, nor is there centralized administration. This is an area of great and residual need.

●—Community Health. A tuberculosis clinic weekly at the state hospital (Glen Gardner) and a periodic clinic conducted by a state psychiatrist from Trenton constituted the only formal approaches to community mental health.

As noted before, nearly half of Hunterdon's population has had some contact with the Center, to date. Emphasis of the Center's program has been the emotional context of disease, as a balance to emphasis on the physical aspects.

The pediatrician, for example, has set forth a plan soliciting the coöperation of parents in treating childhood diseases. Recognizing that the average child most needs his parents when he is ill, the Center encourages the parent to sleep in a cot at the bedside, to dress the child, bathe him, feed him and support him. Parents of children stricken with poliomyelitis are instructed in use of the Hubbard tank for weekends: thus, they participate in continuous care.

●—Emergency Services. Inadequate for the county, the survey found, disclosing also that far too few ambulances were available for emergency aid and transportation.

The Medical Center's well-designed emergency area had 1,800 visits in 1954, of which 1,065 were classified as accident. As part of a state-wide disaster program, the county now has nine rescue and ambulance squads, and 12 ambulances. These squads are composed of volunteers: equipment is provided and maintained through voluntary contributions.

●—The survey also pointed to the lack of a public cancer clinic, the absence of public diagnostic or x-ray laboratories. There was neither immunization service nor any facility for handling contagious diseases. Treatment in neighboring hospitals of Hunterdon children with rheumatic heart conditions rested on no secure basis, since these hospitals faced overcrowding.

The Center is equipped with full laboratory and public health facilities. It handles all but the most delicate special surgery.

special services

●—Blood Bank. At time of the survey, no county agency was large enough to supply blood for transfusions. A list of typed blood donors was maintained, but there was no blood bank, of course.

The blood bank on the ground floor at the Medical Center—one of two permissive Red Cross banks in New Jersey—is open for donations one night per week. Staffing is voluntary, other than a trained technician. Patients drawing upon the bank are charged $5 per pint to cover use of equipment and technician's time. Equipment was purchased through local contributions and a generous allowance from the state.

●—Pharmacy. Eleven pharmacies were scattered throughout the county.

The pharmacy at the Medical Center is equipped and staffed to prepare medications for both hospital and diagnostic clinic.

●—X-ray. Radiological equipment was reported in the private offices of five county physicians and in the state tuberculosis sanitarium at Glen Gardner.

The Center has a radiological laboratory equipped for both diagnostic and deep clinical x-ray. The ground floor laboratory is the heart of cancer clinic operations and related to it physically. Chest x-rays are given routinely—in 1954, more than 13,000 examinations and treatments were listed.

Hunterdon needs a hospital

From this assembled data and his studies on hospital utilization by Hunterdon residents, Corwin affirmed that the county could support a general hospital. He recognized that not all who needed hospitalization would seek admission to the Center—particularly at the outset—but against this could be balanced care of the chronic, certain psychiatric patients who would benefit from general hospital care and patients from adjoining counties.

He noted the possibility of financial help from state and county and urged consideration of endowment income. The actual demand, he said, would be determined inevitably by financial ability to maintain the institution.

In concluding his report, Corwin called attention to possible sources of misunderstanding on the part of local physicians that might have to be clarified. He called for a close working relationship with a larger institution whereby the services of specialists, of laboratory equipment or even teaching skills, might be made available to the Center.

●—On the basis of anticipated 80 per cent occupancy, an annual admission rate of 3,000, Corwin felt the hospital should have 125 beds.

Hunterdon Medical Center was built to provide 106 beds—a reduction partly imposed by rising costs during the building period. Original cost estimates fell far short of the mark: the project was achieved, in final analysis, only through the overwhelming success of a county-wide fund drive.

In November 1954, expansion space in the building was utilized to add 14 adult beds, bringing the total to 120. During 1954, there were 3,420 patient admissions.

●—Sources of income.

County stipends for the medically indigent have been based on cost-plus reimbursement. Endowment funds are expected to play an important role in the future. During the first year—reflecting a normal average occupancy of slightly more than 60 per cent—the Center showed an operating deficit of some $180,000. The present year's experience is more favorable, and the deficit is being met largely through voluntary contributions.

●—Corwin urged a tentative understanding between Hunterdon Medical Center and the New York University-Bellevue Medical Center, noting advantages to each. Foreseen were four fulltime salaried specialists at Hunterdon, who as a condition of appointment would retain teaching appointments at New York-Bellevue. House staff and interns would rotate to Hunterdon under the plan, to staff the Center and gain experience in rural medicine.

The plan had been academically accepted when the Korean crisis developed, making Hunterdon's immediate dependence on rotation for interns and house staff an impractical plan. Today, there are 11 fulltime specialists and three part-time specialists on the staff. Rotation of house staff physicians is an accomplished fact. Office space for the expanded staff has modified the layout of the building, of course, but the six examinations and consultation rooms originally provided in the diagnostic center have proved adequate.

Expanded permanent staff has had the byproduct result of closer liaison between the Medical Center and the county's general practitioners. All fulltime staff specialists now reside in the county proper.

●—Corwin noted skepticism on the part of some local physicians over capital outlay involved in the proposed Medical Center, as well as a fear that the hospital might impose onerous staffing duties on their already overburdened schedules. Concern was expressed that provision of the Center might cost local physicians their courtesy privileges in nearby hospitals, without meeting their needs.

In practice, the Medical Center has proved large enough to serve county residents and doctors, according to Dr. Ray E. Trussell, medical director. At all times, the family physician is responsible for his patients under active guidance of board-trained specialists at the Center, who have ultimate responsibility and authority in critical situations. The specialists urge consultations whenever possible and submit detailed accounts of findings and recommendations to the general practitioner. Though the local physician is not required to make daily rounds, he nevertheless is expected to do so. Local physicians who are qualified are encouraged to do normal obstetrics and to assist in surgical procedures.

exploring

six ventures in design

Wherever men plan hospitals, innovations result. New designs spring up to meet new and unique problems, to keep hospital facilities in step with new concepts in human care.

Featured here are six expressions in design aimed specifically at solving six individual problems. They are widely separated, geographically, and they serve various purposes. Like all good designs, however, they developed only after full identification of the problems involved, only after analysis and deep, earnest planning.

They are representative of America's response to the continuing challenges of ill health and disability.

HERBERT C. MOFFITT HOSPITAL

location:	San Francisco
beds:	483
total cost:	$8,200,000 (including Group I equipment)
cost per sq. ft.:	$26.80
administrator:	William B. Hall
director, hospitals and infirmaries:	R. J. Stull
executive architect:	Milton T. Pflueger, San Francisco
contractor:	Clinton Construction Co., San Francisco
completed:	January 1955

COMPLETION of the Herbert C. Moffitt Hospital early this year was a major step toward fulfillment of long-range goals at the University of California Medical Center. In all, this hillside campus is planned to include nearly 1,000 patient beds integrated with a comprehensive teaching center.

The new 15-story building more than doubles the bed capacity of the Center. The cruciform design was invoked to concentrate patients around a central core. This facilitates vertical supply and the placement of mechanical equipment, and allows office space in the wing of each floor linked physically to an adjoining medical sciences building.

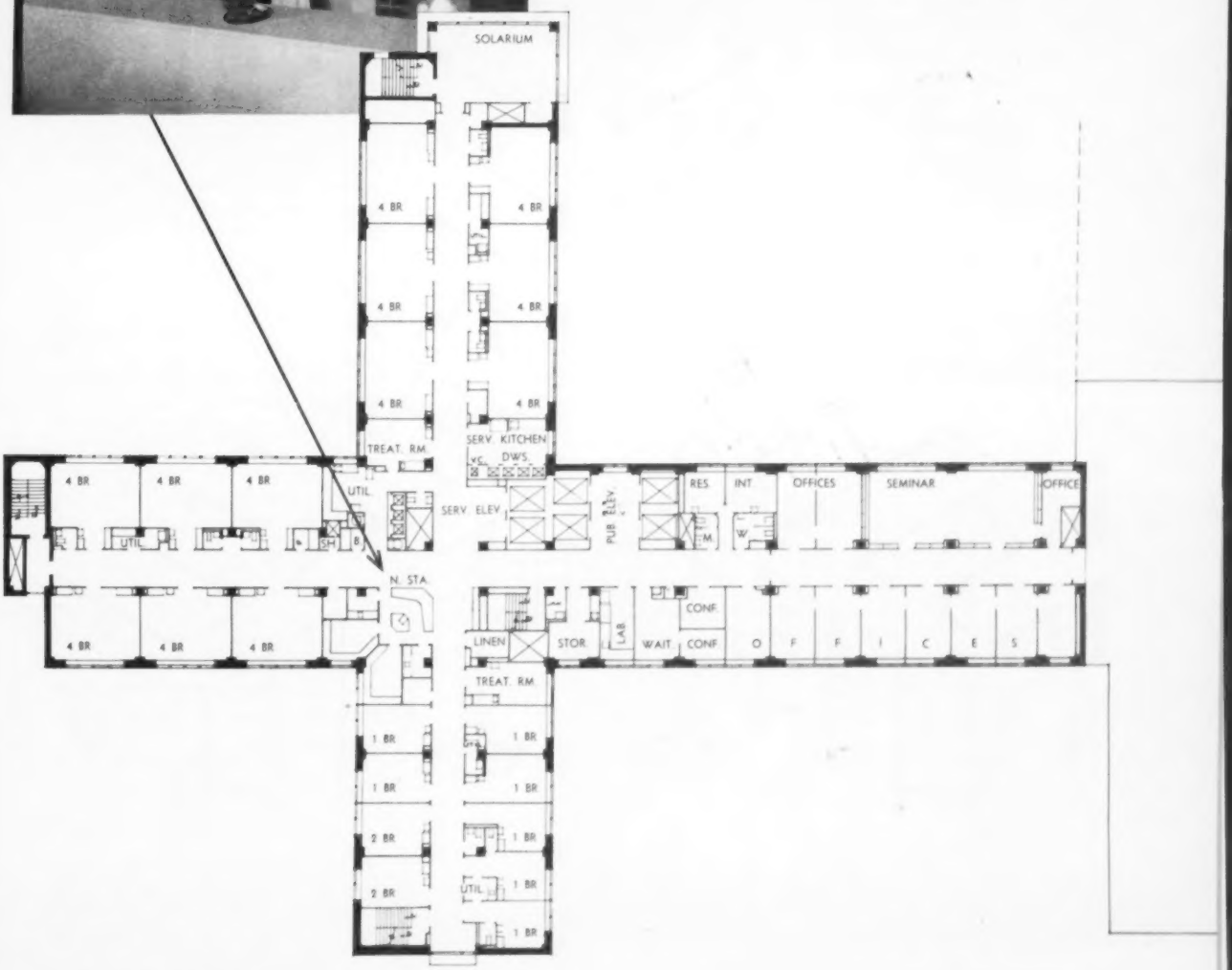
Visitor and admitting areas and ancillary services are grouped in an enlarged "service block" on the lower five floors. Full floors are devoted to surgery, to the dietary department, to radiology and to laboratory facilities. Six high-speed elevators relate these services to the ten patient floors above.

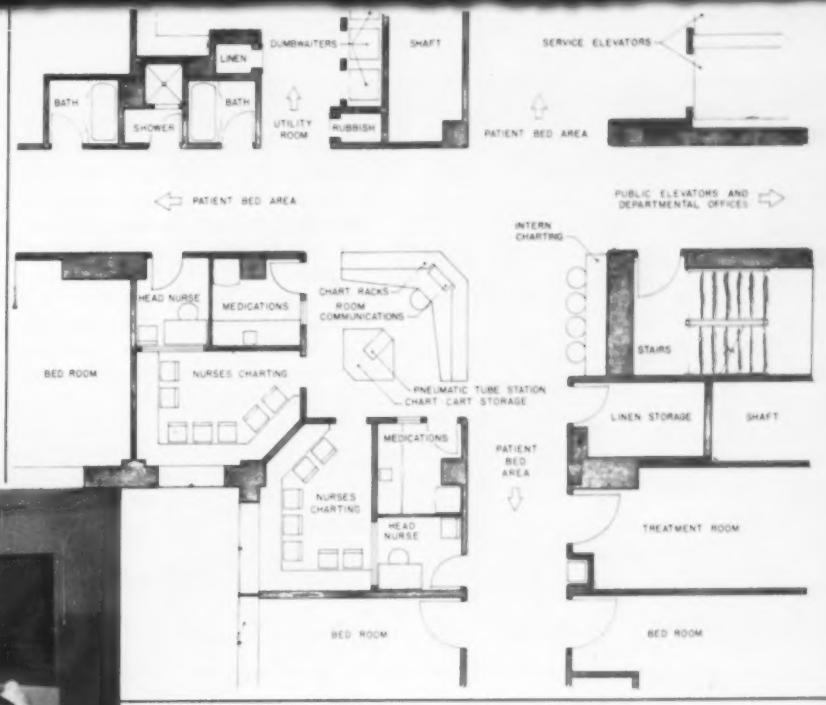
On typical patient floors, the central core planning has led to a unique twin connected nursing station at the junction of the wings. From this vantage point, control is maintained over all corridors.

Each unit of this twin station is responsible for half the floor's 58 patient beds. Ward secretaries for each unit handle records and messages in the single communications center. During night off-peak hours, however, the station is perfectly adaptable to nursing service for the entire floor. Thus, maximum flexibility is obtained.

The plan lends itself, moreover, to optimum supervision of nursing teams in the two units. Duplicate medication rooms, nurses' charting areas and offices reduce traffic and crowding, minimize errors and delays. The charting areas serve as conference rooms for the nursing teams at change of shift.

The location of subutility rooms and bathrooms saves nursing steps. In addition to serving needs for disposal, subutility rooms are equipped for the collection and storage of specimens, an important problem in the teaching hospital. ■





AT HUNTINGTON Memorial Hospital, Pasadena, a growing postwar need for convalescent beds was combined with realization that a special unit could be provided, housed in its own building, at half the cost of additions to the main hospital.

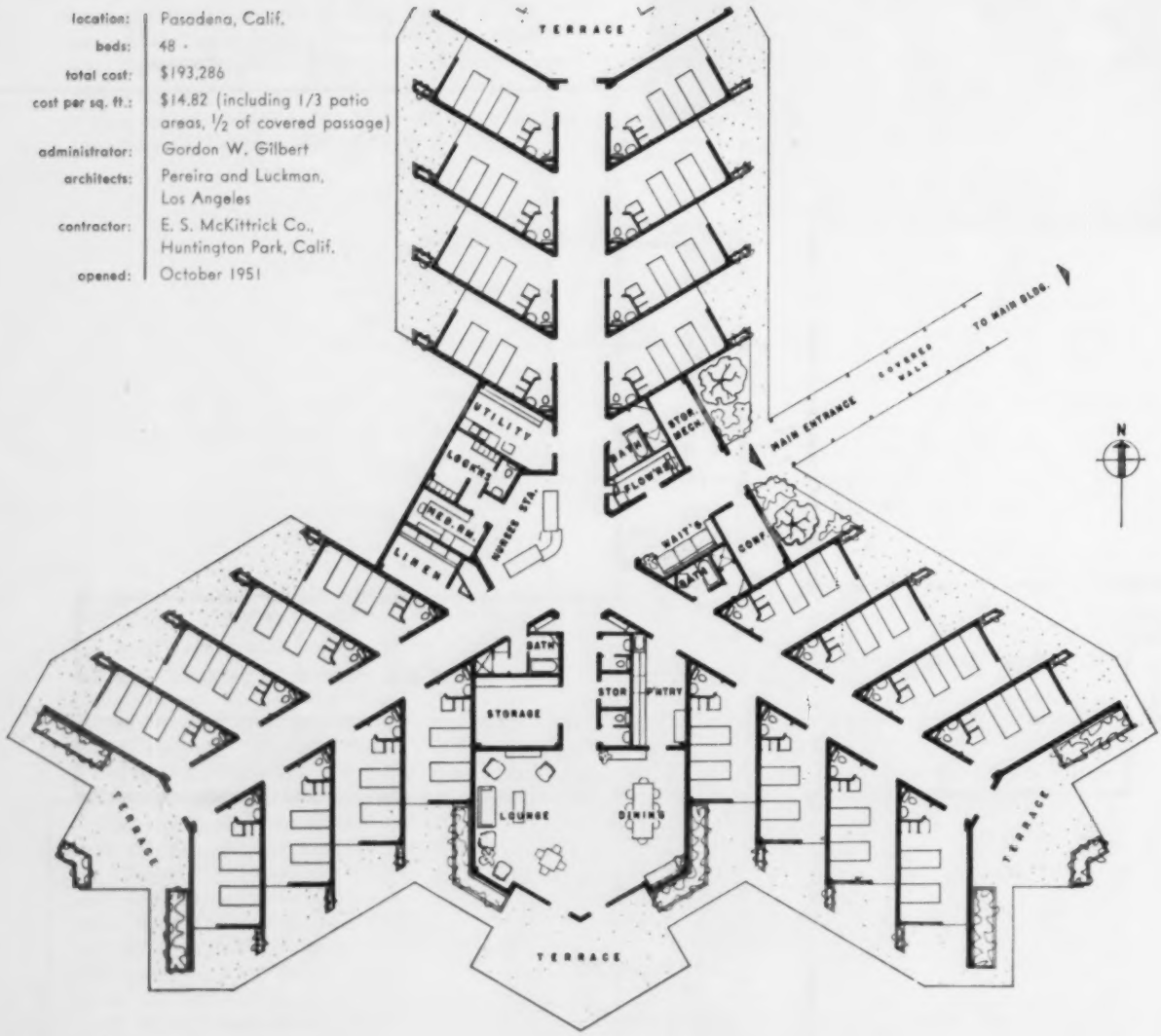
The end product has been the cottage-like Jenks Convalescent Unit, a 48-bed, one-story structure in a true garden setting—removed from the main hospital for privacy, yet related to its services by means of a covered passageway. The unit has increased total bed capacity of the hospital more than 20 per cent.

On this unit, in keeping with the care undertaken, every effort is made to combine patient comfort and self-help with the benefits of a favorable climate. Large twin-bed rooms, with individual toilet facilities, open through sliding glass doors onto individual patios. To insure privacy, these patios are flanked on one side by solid wall, on the other by a planting box and trellis. Doors to the patios accommodate hospital beds. Rooms and patios are planned for maximum exposure to sunlight.

At the end of each wing is a spacious paved terrace for general use on sunny days. A centrally lo-

JENKS CONVALESCENT UNIT, HUNTINGTON MEMORIAL HOSPITAL

location:	Pasadena, Calif.
beds:	48
total cost:	$193,286
cost per sq. ft.:	$14.82 (including 1/3 patio areas, 1/2 of covered passage)
administrator:	Gordon W. Gilbert
architects:	Pereira and Luckman, Los Angeles
contractor:	E. S. McKittrick Co., Huntington Park, Calif.
opened:	October 1951



cated lounge doubles as a dining area for patients who wish to take their meals there. Trays are prepared in the hospital's main kitchen and handled through a special pantry in the new unit.

In bedrooms, each patient has a floor lamp adjustable for direct or indirect lighting. Washable plastic paper on wall behind patients' beds compliments pastel shades on other painted walls—green for rooms with greatest exposure to sunlight, soft rose on rooms opposite. Ceramic tile is used in central showers and asphalt tile flooring throughout the rest of the unit.

Nursing care on the Jenks unit is planned around the patient progressing toward full recovery—the patient who no longer needs intensive care, highly specialized diet or the full therapeutic facilities of the general hospital. Custodial care is not a function. Patients seldom are admitted directly and do not remain on the unit more than 30 days unless their condition demands treatment unique to Huntington Memorial Hospital.

Ease of nursing supervision and a need for central services dictated the Y-shaped design, with the unit's only nursing station, services and the patients' lounge-dining area grouped into a central core. The bulk of nursing care is given by vocational nurses and nurse aides, under supervision of a professional nurse. This saving in payroll alone means two-bed accommodations offered at the same price as ward accommodations in the main building.

The building itself is made up of precast concrete slabs. Roof tile matches other hospital units. The unique plan, with its many angles, called for precision work; but maximum protection against fire and earthquake, and economy, resulted. Wall panels were cast horizontally for economy and for an extra-smooth surface which resembles plaster when painted. Extension of precast partitions from floor to roof, with space left for insulating material, allows complete separation of rooms and soundproofing.

Similar convalescent units may be added in the future as needed. If horizontal expansion is not possible, the plan can be developed vertically. ■

VIEW SHOWING individual outdoor patio outside each patient's room, also lounge terrace.

ABOVE: NURSES' station, located at junction of the three arms of the "Y" plan, has all three corridors under observation, as well as main entrance and lounge. BELOW: LOUNGE-dining room where meals can be served to patients on trays opens to a paved terrace.

INSTITUTE AND PSYCHIATRIC MICHAEL

location:

beds:

total cost:

cost per sq. ft.:

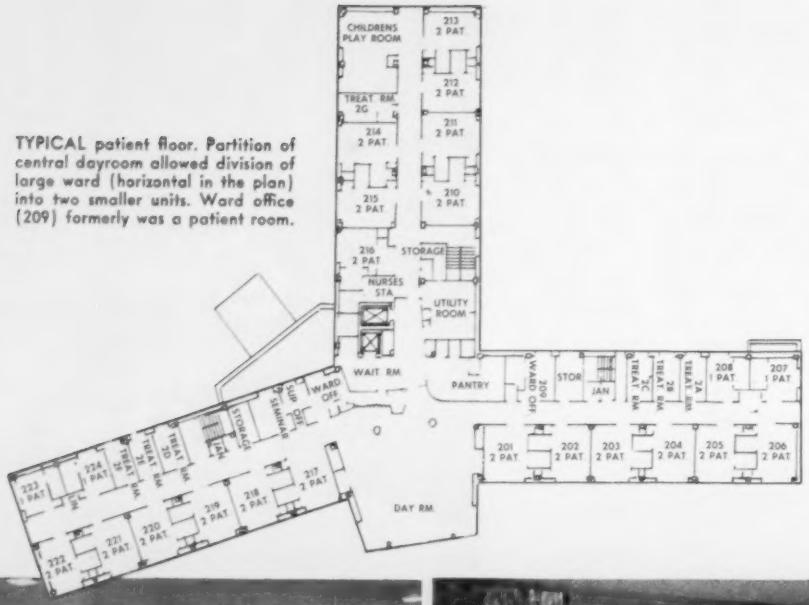
architect:

architects:

consultant:

contractor:

opened:



TYPICAL patient floor. Partition of central dayroom allowed division of large ward (horizontal in the plan) into two smaller units. Ward office (209) formerly was a patient room.

PATIENT LOUNGES are airy and spacious. Note floor-to-ceiling windows, potted plants behind the inside detention screens.

TWIN-BED room—the basic patient unit—is colorful and cheerful, emphasizes homelike surroundings. There are few single patient rooms.

"In psychiatric rehabilitation, the general atmosphere, as well as the attitude of people the patient encounters, largely determines the amount of coöperation for recovery. In this building, therefore, to the limits of the type of care provided, the emphasis shall be on the most homelike atmosphere possible."—ROY R. GRINKER, M. D. director, Institute for Psychosomatic and Psychiatric Research and Training.

EVERYDAY LIVING is the basic concept underlying development of the new 80-bed "P&PI" building at Chicago's Michael Reese Hospital. One of the forerunners in a giant $35 million program of expansion and reclamation, this unit for psychiatric and psychosomatic care is closely allied with the general hospital, designed functionally to combine elements of patient freedom with medical control. The modified T-shaped plan focuses nursing services and control into a central core, allowing maximum supervision and treatment with a minimum of disturbance.

Patient units and private treatment rooms occupy the upper two stories of the building. Rehabilitation services, administration, teaching and research are functionally related on the first and ground floors. Kitchen and supply services are part of the over-all hospital plan.

There are no patient wards in this hospital. People are not accustomed to living in congregation, and the twin-bed room is the basic unit for convalescing patients. Alternative singles are used only when warranted. Rooms have individual toilet facilities, which double as storage for nursing supplies if patients are bedridden.

Light and space are integral with the design. Full windows line patient lounges and butt corridor ends—the visual effect of protective screening is minimized. Wide corridors contribute to the sense of spaciousness. Colors are warm

FOR PSYCHOSOMATIC RESEARCH AND TRAINING, REESE HOSPITAL

Chicago, Ill.
80
$2,000,000
$18.00 (excluding equipment)
Roy R. Grinker, M.D.
Loebl, Schlossman and Bennett, Chicago
Walter Gropius, Cambridge, Mass.
Lloyds Builders, Chicago
June, 1951

cilities and an outdoor play yard.

Superimposed upon this plan are facilities for treatment and control. An enclosed control station overlooks patient lounges and corridors. Six consultation-treatment rooms are located on each patient floor, with thick walls and extra-heavy doors to insure privacy. A special bypass feature allows doctors to enter enclosed nursing station directly from the service lobby, to continue on to the patient unit without retracing steps. A seminar room, part of the nursing station, doubles for briefing of oncoming nurses.

Flexibility is a major factor in the planning. The building was designed for vertical two-floor expansion, for inside modification in keeping with advances in treatment techniques. Identical patient floors evolved from recognition of difficulties inherent in advance measure of the patient load. The children's unit was planned for ready conversion to adult two-bed rooms. Provision was made for subdivision of either of the larger 29-bed patient units by means of pre-built wooden partitions and conversion of a private room into an additional nursing station. Such a division has in fact resulted on the second floor from a decreasing emphasis on psychosomatic care.

Special feature: a holding room has been provided at the ambulance entrance for disturbed patients, pending transfer to the proper patient unit. ■

WALLED GARDEN adjoins first-floor occupational therapy unit. Similar area behind wall at left is fitted out as a playground for the children.

FOLDING DOOR (left) subdivides main occupational therapy room. Not shown is large fireplace, focal point of many activities.

and cheerful. Low, seven-foot ceilings are used throughout.

Men and women are not segregated—a key feature in the plan—although separate facilities and a separate 12-bed ward are maintained for children. Rehabilitation is a mobile concept, patients graduating through four stages from a disturbed unit under constant supervision to an open unit where doors are unlocked.

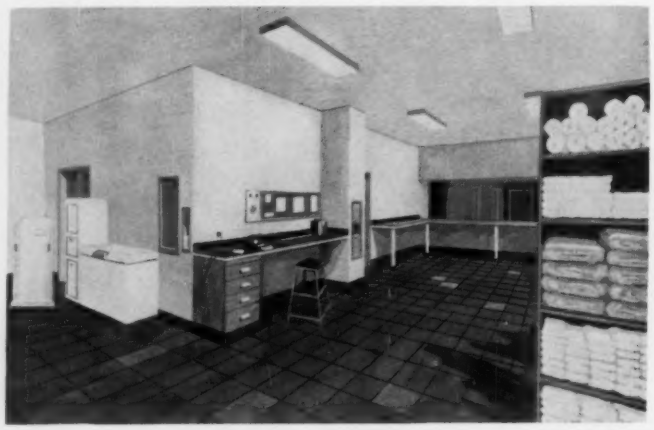
Convalescing patients are encouraged to share in group activities centered in lounges and first-floor occupational therapy. Garden adjoining occupational therapy is as near as an open door. Children make use of special classroom fa-

HARLAN MEMORIAL HOSPITAL

The Memorial Hospital Association of Kentucky, sponsored by the United Mine Workers of America Welfare and Retirement Fund, is erecting a chain of ten hospitals in Southeastern Kentucky and adjoining areas of Virginia and West Virginia. These hospitals, ranging in size from 50 to 200 beds, all incorporate the same basic pattern of design to facilitate supply distribution and minimize wasteful utilization of employee time.

The ten hospitals are scheduled for 1,040 beds, in all.

Harlan (Ky.) Memorial Hospital, with its archetypal supply and distribution featured here, was designed by Sherlock, Smith & Adams, architects, who also designed four smaller hospitals within the Harlan area. The Memorial Medical Center at S. Williamson, Ky., together with three smaller hospitals nearby, was designed by York and Sawyer, architects. Isadore and Zachary Rosenfield, architects, designed the Beckley (W. Va.) Memorial Hospital. E. Todd Wheeler is the coördinating architectural consultant.



DISPATCH OFFICE (above) relates to first floor sterile supply and storeroom areas (see plan, top left). Below, artist's sketch of the finished hospital with nursing school and staff housing at left.

"These hospitals must implement a system that will assure supplies where and when the nurse needs them."

THE DESIGN of 192-bed Harlan (Ky.) Memorial Hospital incorporates elements common to all ten hospitals planned by the Memorial Hospital Association of Kentucky. First considerations are patient requirements and a supply system geared to getting needed items to professional nurses and other skilled personnel.

Distribution of all commodities except food and drugs falls to central stores, adjacent and functionally related to central sterile supply on the first floor. Lightweight carts—rolling storage cabinets—substitute for built-in storage facilities. Emphasis is placed on vertical transportation, intercommunication, mobility and automatic delivery of supplies up to pre-arranged standards.

The great majority of treatment trays required for patient care will be delivered from central stores either to clean utility rooms—each of which serves an entire patient floor—or to the outpatient utility area. Central stores will assume responsibility for keeping complements up to a standard.

Carts similar to those used for treatment trays will be placed on each patient floor in a soiled utility room, to receive soiled articles for transportation to the cleanup area of central sterile supply.

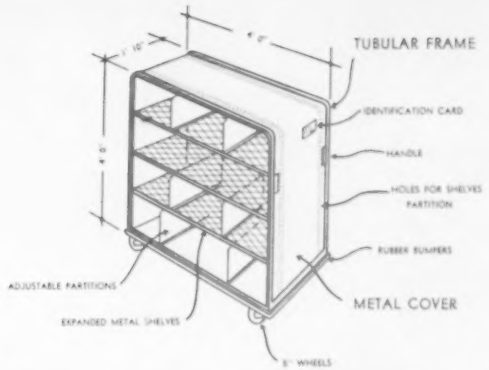
To provide for all contingencies

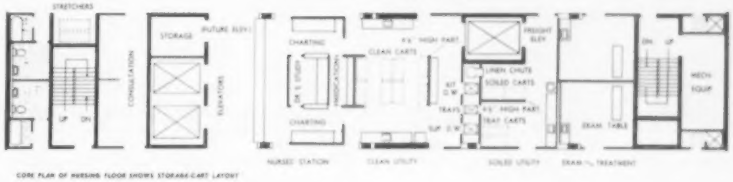
and guard against overstocking, the cart system is augmented by direct dumbwaiter connection between central stores and floor utility rooms. Arrival of a dumbwaiter cab sets off a visual and audible signal in both the utility room and the nursing station. Orders beyond anticipated needs are conveyed to the storekeeper via loudspeakers in the stores area, to which any telephone in the hospital is planned to connect through the switchboard.

Carts will be equipped with movable shelving, allowing ready conversion for a variety of purposes. One such cart in each utility room, for example, will supply intravenous solutions. On another will be stocked miscellaneous supplies and paper goods. Others will be used as portable linen shelves, stationed in utility rooms except during morning bed-making times when they are moved to patient corridors.

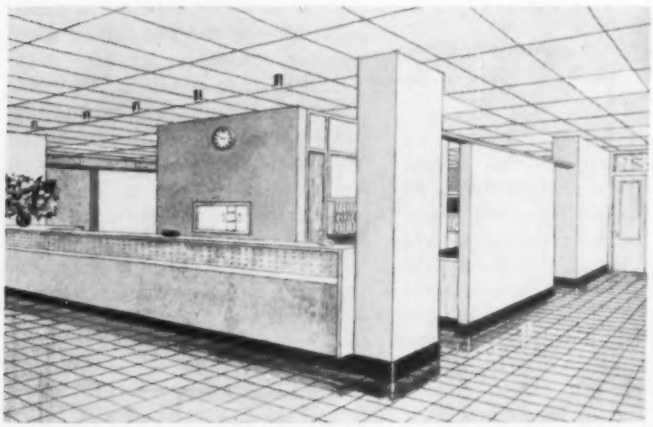
Easy modifications will convert the basic cart into a pharmacy distribution wagon or maid's cart.

There are no food facilities provided on patient floors. Tray conveyors will operate through the vertical supply core during mealtimes, transporting trays and removing dirty dishes. The adjoining dumbwaiter will handle all food requirements between meals and special items during the meal rush. Direct intercommunication not tied to the switchboard is provided between the central kitchen and patient floors. ■

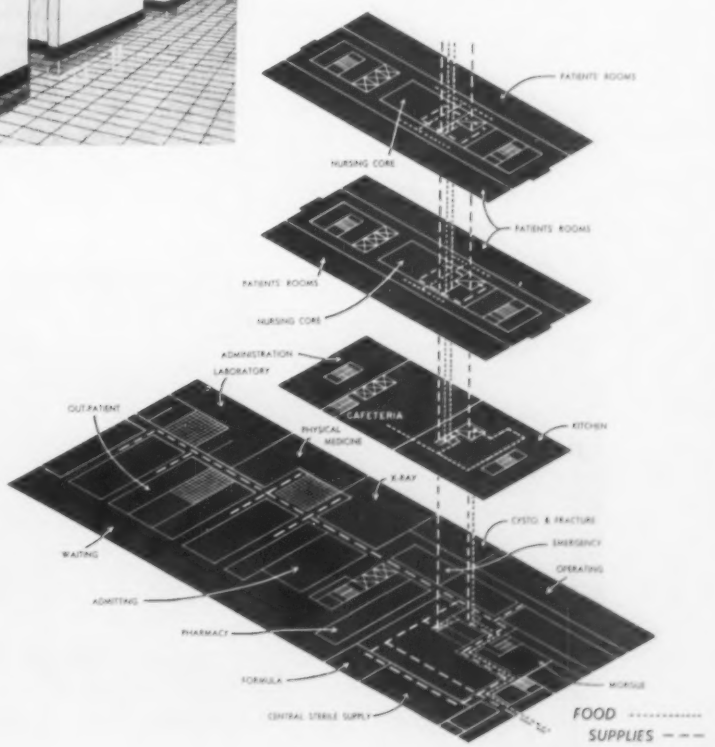




CORE PLAN OF NURSING FLOOR SHOWS STORAGE-CART LAYOUT



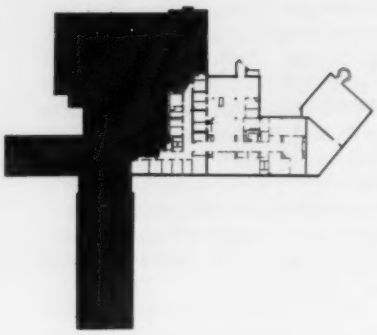
NURSING STATIONS (left) on patient floors front utility rooms (see plan, above). Supply carts wheeled into position serve as cabinets: their movable partitions and shelving permit flexibility in use. Below, vertical distribution plan shows movement of food and supplies.



INSTITUTE OF PHYSICAL MEDICINE AND REHABILITATION
METHODIST HOSPITAL DIVISION

location:	Peoria, Ill.
beds:	(none)
total cost	$272,000*
cost per sq. ft.:	$34.00
administrator:	Phillip R. Hagen
medical director:	H. Worley Kendall, M.D.
architect:	E. I. Harrison, Peoria
contractor:	George Johnson, Peoria
opened:	March 1954

*Including equipment and leasehold improvements.



"Actual rehabilitation is something which takes place in a community rather than a building. While the physical plant furnishes a central point for diagnosis, treatment and guidance, the actual channels of the rehabilitation process extend to all the facets of community life."—H. WORLEY KENDALL, M.D.

IN 1948, PEORIA'S nonprofit Forest Park Foundation made a far-reaching decision. Work began on a 125-bed inpatient facility where care of the community's convalescent and chronically ill could be related to the services of a large general hospital. The emphasis was on rehabilitation of these patients, a return to normal living.

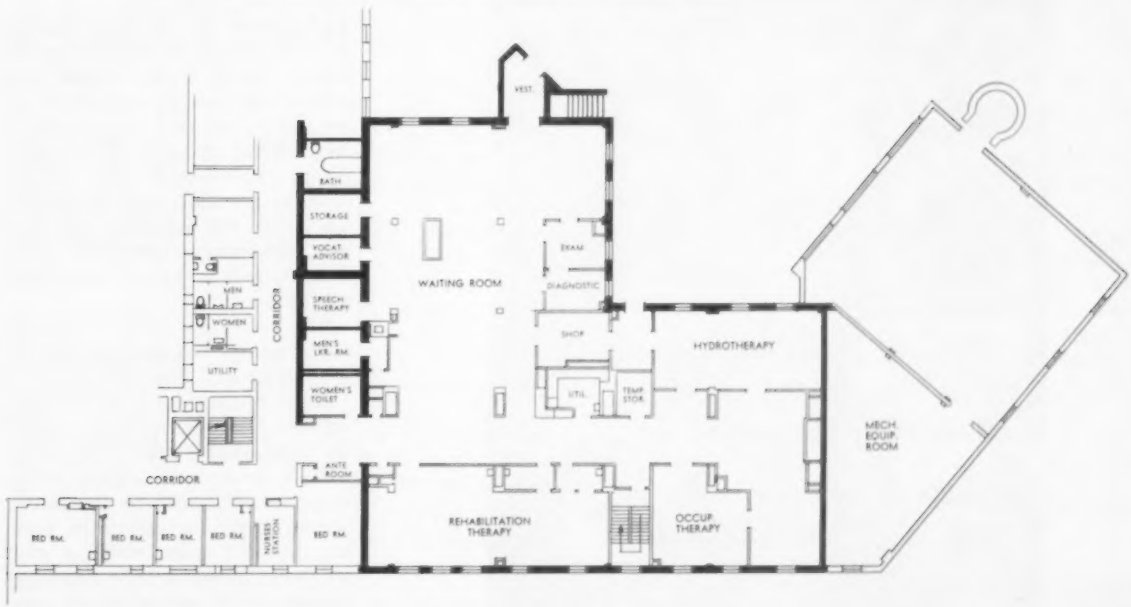
By 1950, in response to community need and growing demands of the program, specialized rehabilitation services had emerged in their own right as the Institute of Physical Medicine and Rehabilitation, a separate nonprofit corporation. Under a unique plan, the Institute placed units in Peoria's two largest general hospitals (1,250 beds in all), offering trained technical service and the use of specialized equipment at less than actual cost. It serves local physicians as a consultant in rehabilitation—preparing written recommendations and encouraging joint conferences, providing complete services. All patients remain charges of the referring physician.

In both units, facilities are made available for outpatients (Institute patients) and to the hospital for inpatients. Community needs and responsibility underlie all activities of the Institute.

The Methodist Hospital Division, as featured here, incorporates nearly three years of working experience gained from an earlier unit at St. Francis Hospital. Two key concepts evolved during this period—provision of inpatient care on the same floor as the treatment areas, and complete air conditioning. Air conditioning allows uniform treatment the year round and balances heat from therapy equipment, while the unilevel planning concept means economy, added safety and elimination of cross-traffic.

In the newer unit, overhead equipment supports in all treatment areas are bedded in concrete for structural strength. Lights are flush with the ceiling for uniform illumination over working areas. Rooms are soundtreated. Facilities for physical therapy are grouped

GROWING DEMANDS of the program will see modification of the existing lobby area (above) to provide more working space.



for isolation from noise and traffic flow.

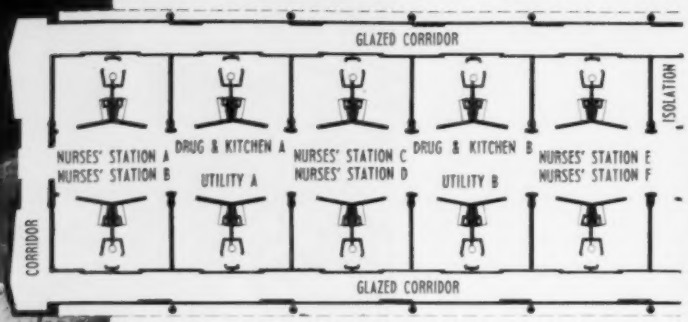
Adjoining inpatient facilities now being provided (plan, above) will promote patient self-help. The four-bed ward plan used exclusively for rehabilitation inpatients at St. Francis Hospital is carried into this new unit, since examples set by convelescing patients mutually encourage self-help.

A training toilet area will open in two directions, with space left around the bathtub for support from two sides. Rails will be installed in patient showers for support—an anchored chair faces two nozzles, one waist-high, the other shoulder-high. Shower controls are located on the opposite wall for safety and convenience.

Constant modification is being made to meet new conditions. Addition is planned, for example, of a garden and outdoor area. When inpatient beds are ready, the present design will be modified to allow traffic flow in just one direction, toward a central reception desk in the main lobby. The present entrance will be abandoned at that time.

Provision is made for horizontal and vertical expansion. ■

FOUR distinct nurse units serve each group of eight patients—facing nurses' stations and a pair for kitchen-drug services and utility.



TWO CENTER views show how (1) light and air are integral with recovery plan. Outdoor visitor walkways are shielded under roof overhang. (2) Major innovation is central work corridor that brings to the doctors and nurses everything needed for care of the patient, close to his bedside.

PLANNERS OF THE new Kaiser Foundation Medical Center at Walnut Creek, Calif., sought two main objectives—nursing efficiency and patient comfort. For efficiency, they turned to an earlier Kaiser design transforming the central hospital corridor into a nursing workshop. For comfort—and further efficiency—they installed a wide variety of patient self-service features.

The result has been a modern, functional 94-bed general hospital with some real innovations.

Heart of the plan is the working corridor. Here, everything needed for care of the patient is placed outside the door to his room, at the immediate disposal of the nurse. Visitor traffic is eliminated from the corridor completely—a roof overhang shields outside walkways opening to all patient rooms.

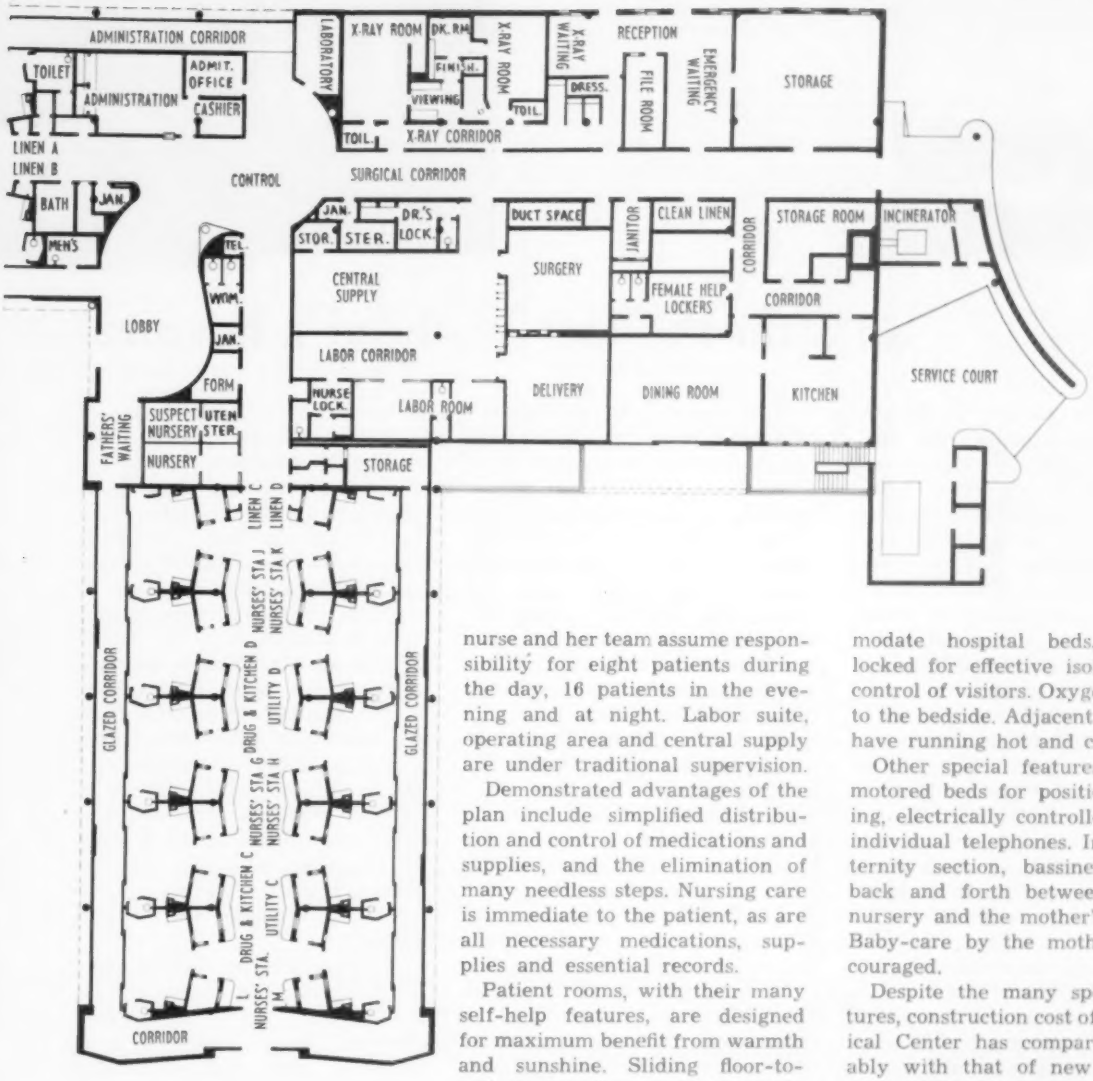
Each group of eight beds is served by four distinct work units —a facing pair of nursing stations on opposite walls of the corridor, a second facing pair for drug-kitchen needs and utility services. Standard supplies are delivered routinely, emergency supplies to order. Medications are delivered only on doctor's orders, to be then placed in the patient's individual medicine cabinet.

Team nursing is in effect, with different schedules worked out for day, evening and night duty. Under general direction of an area supervisor, the professional staff

KAISER FOUNDATION MEDICAL CENTER

location:	Walnut Creek, Calif.
beds:	94
total cost:	$1,325,400 (including Group I equipment)
cost per sq. ft.:	$26.00
medical director:	Sidney R. Garfield, M.D.*
architect:	Clarence Mayhew, San Francisco
contractor:	California Builders, Oakland
opened:	September 1953

*Dr. Garfield served as functional designer and medical consultant



nurse and her team assume responsibility for eight patients during the day, 16 patients in the evening and at night. Labor suite, operating area and central supply are under traditional supervision.

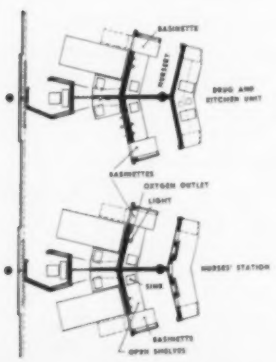
Demonstrated advantages of the plan include simplified distribution and control of medications and supplies, and the elimination of many needless steps. Nursing care is immediate to the patient, as are all necessary medications, supplies and essential records.

Patient rooms, with their many self-help features, are designed for maximum benefit from warmth and sunshine. Sliding floor-to-ceiling glass doors, which accommodate hospital beds, can be locked for effective isolation and control of visitors. Oxygen is piped to the bedside. Adjacent lavatories have running hot and cold water.

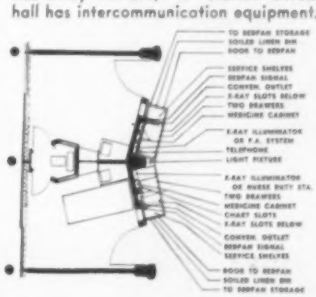
Other special features: electric motored beds for position changing, electrically controlled drapes, individual telephones. In the maternity section, bassinet shuttles back and forth between private nursery and the mother's bedside. Baby-care by the mother is encouraged.

Despite the many special features, construction cost of the Medical Center has compared favorably with that of new hospitals in the area. ■

(BELOW) MATERNITY corridor nursing stations have view windows into infants' private nurseries. Door between corridor and bedroom leads into nursery. (RIGHT) Unique shuttle allows bassinet to pass between nursery and mother's beside. Note adjacent lavatory facilities.



(BELOW) BASIC nursing station has records, charts, medications, reports for four patients. "A" station has x-ray viewers; "B" station across hall has intercommunication equipment.



evaluating

an after-the-fact study of a hospital

LATE LAST OCTOBER, in Dayton, Ohio, more than a dozen leaders in the hospital field assembled at the new 600-bed Miami Valley Hospital for an intensive two-day symposium on design of the hospital, its facilities, equipment and procedures.

At the invitation of Dr. Frank C. Sutton, hospital director, the group was being asked to evaluate plant and procedures on the basis of the first year of operation. Carefully-planned sessions—seven in number—would explore major areas of interest. Department heads and personnel, the architect, contractor and consultant, all would be on hand to answer questions relating to design and function. Pre-assembled information kits with sample forms and detailed accounts had been prepared for distribution.

Frankness was encouraged. It was seen that open criticism and counter-suggestion would lead to a synthesis of group opinion.

A guided tour of the hospital was first on the agenda. Subsequent daytime sessions explored admission procedure and special equipment, communications systems, operating room facilities and Miami Valley's well-developed system of central distribution and supply. An evening session was devoted to group discussion on the most advantageous ratio of employees to patients in the 600-bed hospital—"How much is service worth to the patient? How many employees does it take?"—and one session considered various plans for management of food service.

Time was allotted, as well, for a period of "bursting balloons," as one of the participants put it. Among "balloons" tossed up for discussion were public elevators purposely designed to exclude hospital beds, as part of a basic plan to separate hospital traffic from visitors. In view of the trend toward early ambulation, a question arose over elimination of solaria at the end of all patient wings—four on each floor—in favor of two centrally-located dayrooms.

Answers to these, and some other questions, were left frankly unresolved, but their exposition indicates a wide range of opinion and highlights problem areas in want of objective research and more consideration.

Of greatest significance, perhaps, is the feeling of basic agreement and satisfaction that emerged from the conference. A diversified group representing diverse opinion was noting with approval solutions to chronic problems of design and function without sacrificing other —and perhaps equally sound—solutions to these problems.

Proper evaluation was the end product.

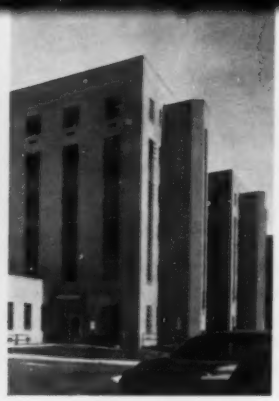
The Miami Valley Hospital symposium points the way to similar conferences in the future, in which research can be brought to bear, opinions aired and evaluation reached. ■

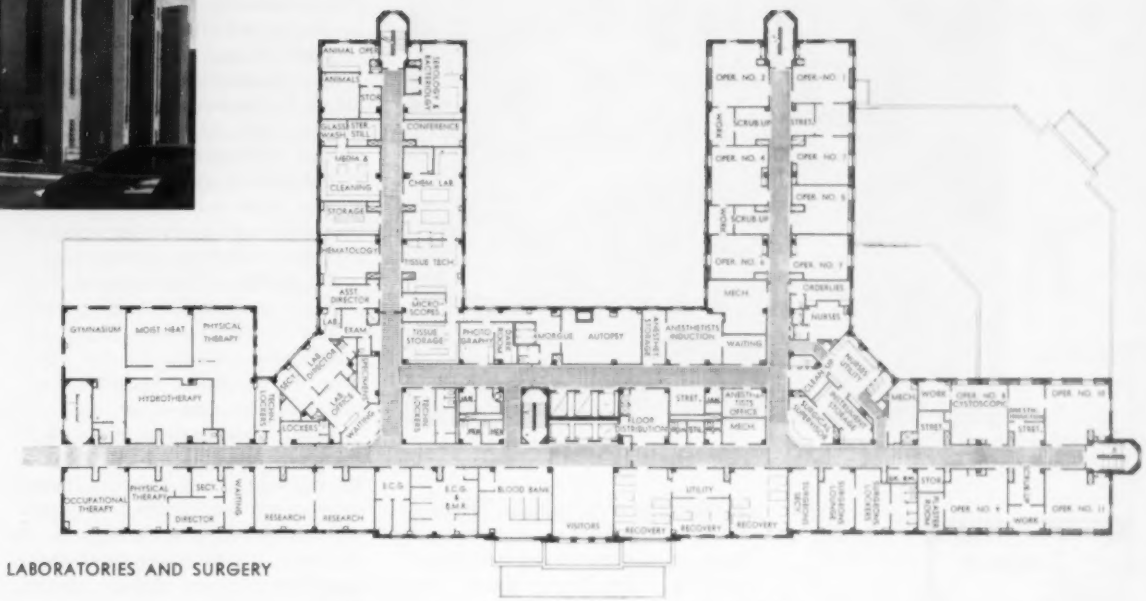
MIAMI VALLEY HOSPITAL

MAIN entrance lobby. Reception desk is right and gift shop left at end of lobby.

location:	Dayton, Ohio
beds:	511, expandable to 635
total cost:	$6,700,000
cost per sq. ft.:	$21.00
director:	Frank C. Sutton, M.D.
architect:	Harry I. Schenck, Dayton
consultant:	Christopher Parnall, M.D., Ann Arbor, Mich.
contractor:	Maxon Construction Co., Dayton
opened:	December 1953

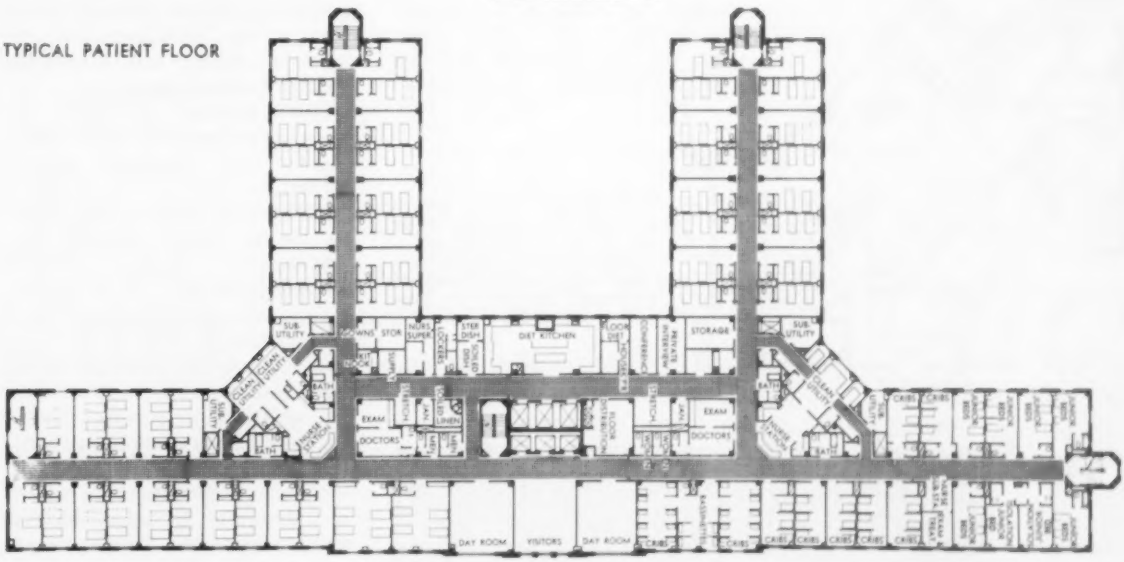
SINCE MIAMI VALLEY Hospital opened the doors of its new building in December 1953, occupancy has climbed steadily from a starting 80 per cent to some 87 per cent today. Over 20,000 patients are admitted annually, approximately half for major or minor sur-





LABORATORIES AND SURGERY

TYPICAL PATIENT FLOOR



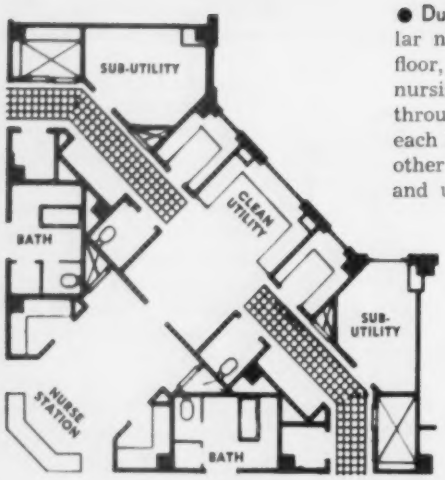
gery. The largest hospital in the Dayton vicinity, Miami Valley serves surrounding counties on virtually all such specialty cases as thoracic surgery, cardiography and neurosurgery.

The hospital reports 600 beds. Flexibility in private room accommodations and dayroom conversion, however, allows a range of 511 to 635 beds.

Distinctive features include parallel corridors for clear separation of hospital from visitor traffic, and a concept of central distribution built around automatic delivery and a "wholesale" center to supply "retail" outlets. Twin duplex nursing stations on each patient floor allow maximum flexibility of service (see pp. 96-98).

All essential areas are air conditioned. Oxygen is piped throughout the building. Special features: intercommunication is provided between x-ray stations; admitting procedure utilizes quickly embossed metal plates and pre-assembled, multicarbon forms routed to all essential departments and services.

Complete facilities include 12 operating rooms. Three integrated recovery units accommodate up to 20 beds, 50 per cent greater capacity than the going standards. All operating rooms accommodate specialty surgery and are serviced from central sterilization rather than individual units between two operating rooms. Patients are transported to surgery in their own beds.



● **Duplex Nursing Stations.** Triangular nursing stations, two on each floor, are located at the junction of nursing wings. If you draw a line through the center of the station, each half is a mirror image of the other; each has duplicate medicine and utility rooms, a key feature.

TWO DUPLEX nursing stations are located on each floor. Either side of station (below) controls a single service when necessary. Clean utility room (above) off cut-through corridor saves many nursing steps (Note plan at left).

A consultation room (across the corridor) doubles as physician's charting area. Thinking behind the plan: separation helps reduce congestion at the station, reduces errors and delay.

Intercommunication facilities are provided between the nursing station and all patient rooms served. Patient's faintest whisper is audible at station. Nurse call system with wall speakers saves valuable steps, as does service subcorridor behind the station.

Flexibility is the keynote. Duplex stations are adaptable equally to one or two services. As an example, one station on the third floor serves both pediatrics and eye, ear, nose and throat.

Team nursing is in effect, with three or four teams each headed by a professional nurse assigned to each station. Under general supervision, teams attend 15 to 18 patients. An assistant head nurse performs many routine duties, freeing head nurse or floor supervisor to assist physicians and circulate more freely among patients and the nursing teams.

Other features: an emergency signal in each patient toilet flashes corridor light and special light in the nursing station. Intercommunication system doubles as a nurse monitor to augment rounds, provide protection for nurses entering disturbed rooms.

Group Critique. Duplicate flower rooms (next to bath in the plan, left), which proved unnecessary, have been converted into medicine rooms. Alcoves originally provided for medications proved wholly inadequate.

Though hospital officials pointed out duplicate facilities—such as utility rooms—as integral in the planning, question was raised over allocation of space to such duplication. The group queried the attitude of nurses toward the larger patient unit, with resulting explanation that nurses now indicate preference for the Miami Valley plan.

Minor criticism: advantages of a glass-enclosed station might oversway the reason for an open station in Miami Valley Hospital, i.e. nurses on night duty can hear and investigate unusual sounds.

General Consensus. A sound, workable plan.

● **Central Distribution.** Central supply already figured into the design when planners took a step forward. "Why not a wholesale center with various retail outlets?" they asked. They envisioned central supply, pharmacy and processing areas grouped around a central distribution area, feeding distribution stations on each floor.

It was a plan they could adopt, and did.

Automatic delivery to nursing personnel of all supplies except potent drugs is integral to the plan. High quality nursing care is fostered with fewer nurses.

Central distribution, on the ground floor, is adjacent to supply and sterilization, to pharmacy and storerooms. On a 24-hour basis it handles supply items and equipment most frequently used, as well as hospital mail and a host of other items. Master station for the 16-station pneumatic tube system is located here. Floor distribution outlets, open 7 a.m. to 10 p.m., are served vertically via parallel dumbwaiters reserved respectively for sterile and nonsterile items and by adjoining service elevators that face onto service corridors.

Linen and those items less in demand, also delivered automatically, fall to separate storerooms and control. All supplies are checked against pre-arranged standards on each floor and for rotation of supplies.

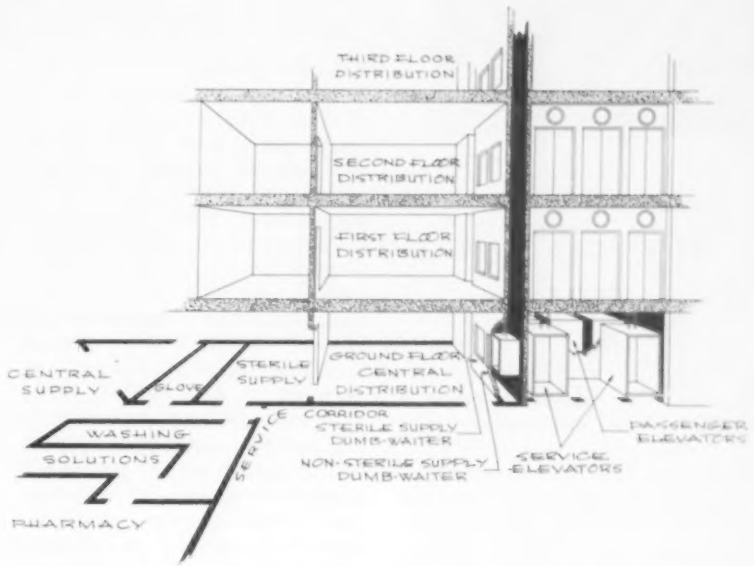
Heading central distribution at Miami Valley is the chief pharmacist. Thinking behind the plan: though special training is involved, the pharmacist normally is charged with medical supplies and equipment. He is, therefore, the most logical choice.

Group Critique. 1. Separation of storeroom supplies from the distribution system. Justification: a functional arrangement. Floor distribution stations handle only the items most frequently used.

2. The economics surrounding central distribution. Justification: 21 employees are involved, a payroll approaching $50,000. Balanced against this are savings in steps and elevators—as for example—better control on the floor, economy in time. Plus the intangible saving in better patient care.

3. Adequacy of certain equipment to do the job—specifically, the dumbwaiters (two), pneumatic tube system requiring personnel at a master station, the size of sterilizers in central supply (two, each 36" x 48" x 84"). Justification: sterilizers are sized to demand. Dumbwaiters, while adequate for central distribution, are not available for other services as originally planned. Studies are anticipated on the reservation of dumbwaiters for sterile and nonsterile items, on peak loads, on number of trips. Regarding pneumatic tubes, a number of new systems have appeared on the market since hospital was planned, some obviating the master station.

General Consensus. Good plan, working well in operation. Perhaps the forerunner to similar installations in the future.



CENTRAL distribution on ground floor relates vertically to floor distribution rooms. It is keyed to nearby processing and storage areas horizontally.

CENTRAL distribution room on ground floor handles important supplies and equipment, hospital mail, gifts and flowers. At left is the master station and control point for the hospital's 16-station pneumatic tube system.

● **Parallel Corridors.** A third distinctive feature is the provision on all floors of parallel main and service corridors, each served by its own bank of elevators, each performing separate functions. Thinking behind the plan: visitor traffic is divorced from hospital work activities—the delivery of linens and food trucks, for example, and transportation of patients. The impression of confusion is reduced by elimination of all crossed lanes of traffic.

Service elevators, as noted previously, are adjacent to central distribution on ground floor and to distribution points on all other floors. These accommodate patient beds, while patient elevators do not. Elevator banks are back-to-back. (See floor plan below.)

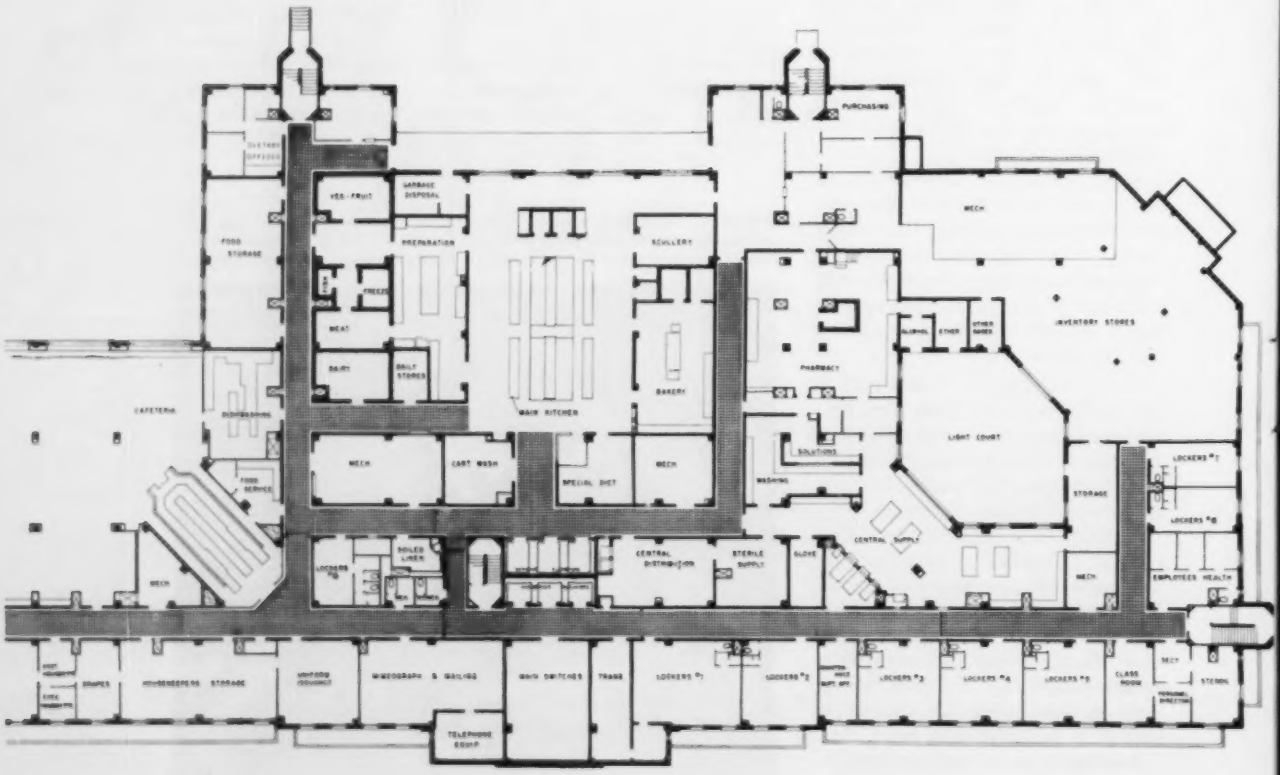
On patient floors, the service corridor opens on both ends to nursing station area. It serves such floor workrooms as distribution, storage and staff lockers, diet kitchen and staff offices. On the ground floor, the corridor provides an external link between central distribution, central supply and pharmacy, and affords direct access to loading docks and receiving area.

In event of a wide-spread community disaster, double corridors would facilitate simultaneous transfer and evacuation of patients.

Group Critique. No criticisms on the basic plan. Question raised, in regard to elevators, about possible difficulties to be encountered in evacuation of patients in the event of an internal hospital disaster. Justification: hospital is zoned for horizontal evacuation. Beyond this, service elevators can perform this function.

General Consensus. Plan eminently justified in a hospital of this size. With regard to sizing of elevators, there are fewer bedfast patients today. More patients, therefore, can be served in passenger type elevators. ■

GROUND FLOOR PLAN



research in function and design

R. LLEWELYN DAVIES

THE NEED FOR RESEARCH into the functioning of hospitals as a basis for planning is now widely accepted. I think it has probably been accepted here in the United States for rather longer than it has in the United Kingdom. There is, however, still debate and sometimes confusion as to just what research is wanted, and just what it can do. We get confusion because the purpose of research gets mixed up with its method.

The purpose of research into hospital functioning, as of other kinds of operational research, is to help people—hospital administrators, doctors and architects, for instance—to make the right decisions. What is sometimes forgotten is that research cannot make these decisions for them. In fact, decisions on how to run or design a hospital must often be taken on a basis of hunch and judgment rather than on fully-ascertained fact, and this will remain true, however much research we are able to do.

In reaching a design for a hospital, the architect has to weigh all aspects of the problem and make judgments about the relative value of things that cannot be compared numerically, or in terms of money. What research can do is to illuminate some aspects of the problem and provide him with data, information and methods of analysis which will enable his imagination to work on a better and fuller understanding of the various conflicting needs he has to meet. Research data can give tools to the architect, the hospital management and administrators, but it cannot do their job for them. If this is not realized clearly, research may start off on the wrong foot as an attempt to provide final and complete answers to the problem.

It is rather like the early days of medical research which, you will remember, set out originally to discover the elixir of perpetual life. More headway was made in medicine when they settled down to tackling rather more limited problems. Medical research today does not attempt to standardize diagnosis or treatment; it aims to give the practicing clinician essential knowledge and leave its application in any particular case to him.

Mr. Davies is director of the Division for Architectural Studies, The Nuffield Foundation, London, England. Under the chairmanship of Leslie Farrer-Brown, director of the Foundation, Mr. Davies and his colleagues have been conducting an investigation into hospital function and design as it relates to the nursing unit, outpatient department, operating theater and several other elements of the general hospital. Their investigation, under the auspices of the Foundation and the Nuffield Provincial Hospitals Trust, also has included a major study aimed at relating the provision of hospital services to the population served. This paper is the text of an address delivered by the author to the 56th annual convention of the American Hospital Association in Chicago last September.

ANALYZING THE PROBLEMS

One of the most important things we have learned in the five years that our team has been studying the function and design of hospitals is the need to break down our problems into aspects or facets that can be studied objectively.

Suppose you start with the problem, for example, of what is the best design for a hospital ward. So long as you leave the problem in this general form there is not a lot you can do to study it. You can look at wards that have already been built. Some may look better than others; some may be said to work better than others; but it will be difficult to reach any conclusion or make many objective comparisons between them.

You can organize surveys and questionnaires designed to show what the nurses, doctors and patients think of the buildings they use, and a great many studies have been planned and carried out on these lines. The trouble is they tell you very little when you have done them. They only tell you what a number of people think about the questions, i.e. the results are purely subjective.

Further, and this is very important, the people who work in a building usually criticize it only in terms of the particular pattern of work to which they have become accustomed. This pattern may not be the best one and it is very likely to have been influenced by the design of the buildings in which it has arisen. Therefore, the views expressed will probably contain no effective fundamental criticism of the design.

We found that general inquiries and questionnaires only brought us to one conclusion—that there are a lot of different designs for hospitals, and a lot of conflicting views as to which of them is the best. We therefore set to work to break down the problem of design into a number of different issues susceptible to closer study. Perhaps I can illustrate this with reference to studies we have been making in the design of the nursing unit.

THREE GROUPS

These studies fell roughly into three groups: medical, nursing and architectural. The principal MEDICAL STUDIES, made by a doctor who was a member of our team, were as follows:

1. A survey of the degree of dependence of patients. This survey was intended to give a picture of

type of regime*	I. BEDFAST (per cent)	II. PARTIALLY AMBULANT (per cent)	III. FULLY AMBULANT (per cent)
	A. GENERAL SURGERY: 155 PATIENTS		
actual regime	50.3	20.0	29.7
early ambulation	16.4	35.0	48.6
traditional	66.7	17.3	16.0
	B. GENERAL MEDICINE: 167 PATIENTS		
actual regime	53.3	24.6	22.2
early ambulation	25.7	28.3	46.1
traditional	61.1	13.9	25.0
	C. GYNECOLOGY: 109 PATIENTS		
actual regime	46.8	33.0	20.2
early ambulation	16.2	45.5	38.4
traditional	55.7	31.0	13.3

*The percentages for "early ambulation" and "traditional" regimes are based on estimates by medical staff consultants.

fig. 1

the proportion of cases likely to be found in hospital wards in three categories—bedfast, partially ambulant (that is, able to use toilets and washing facilities) and fully ambulant (that is, out of bed for the greater part of the day). Such information is, of course, vital to the determination of many issues in ward planning, such as the provision of toilet facilities, the size and placing of the day room and so on. The proportions differ, of course, between different medical specialties, and the results are based on a fairly large survey covering many hospitals. Fig. 1, above, shows some of the results of this study.

2. A survey into the proportion of cases likely to require single rooms or cubicles on medical grounds. Apart from the provision of single rooms for private paying patients, it is necessary to provide a proportion of beds isolated in cubicles or single rooms for such cases as need this accommodation on medical grounds. The results of the survey showed a wide fluctuation from time to time in the demand, and the data were subjected to statistical analysis in order to help hospital authorities in determining the appropriate provision, taking these fluctuations into account. Fig. 2, below, shows the result broken down into two types of room, "A" requiring close supervision and "B" not requiring it. This distinction obviously is important in planning.

3. The relationship between cross infection and planning. This was a survey of cross infection in a number of hospitals. It was made in an endeavour to establish what measures could be taken in planning to reduce cross infection. The results of all these studies have been published in the *Lancet*.*

NURSING STUDIES were much concerned with work methods and job allocation and were therefore made by the nurse member of the team, working together with our time-study engineers:

1. A study of journeys made by nurses in the course of their work. This study established what proportion of the total journeys were from bed to bed, from bed to the different ancillary rooms and from ancillary room to ancillary room. The results gave some guide to the relative placing of the different elements in the ward plan and underlined the importance of compact arrangements of the bed areas. Fig. 3 (p. 101) shows a trace of the movements of a nurse during one shift.

2. A study of the space required for nursing. There is a good deal of debate as to how much space is needed around the patient's bed for the nurse to do her work. We made a motion picture of a patient being nursed, with the background marked out in foot squares. We could thus see how much space was needed for the various jobs and how often it was in use during the day. I should say that, in order to be on the safe side here, our cast consisted of the plumpest nurses the hospital could supply.

3. Experiments in nursing organization. Following a job analysis of nursing in English hospitals made by another research team, sponsored by the Nuffield Provincial Hospitals Trust, we have begun to develop a system of team nursing that breaks away from the traditional concept of the English ward (in which nursing and administrative duties for a group of patients are focused on the ward sister). We are working towards a nursing unit of 16 to 20 beds under the charge of a qualified nurse, a number of these units being grouped together to form an administrative unit under the sister. We think this idea, whereby each nurse looks after a small group of patients for whom she does everything, will give much better nursing than the prevalent arrange-

medical ward, 16 beds (based on data from 10 wards)

	NUMBER OF SINGLE ROOMS 1	2	3	4	5	6
both types of single room						
efficiency of provision (%)		47	67	82	92	97
efficiency of utilization (%)		97	92	84	75	66
type-A rooms only						
efficiency of provision (%)		65	84	94	98	
efficiency of utilization (%)		86	74	62	52	

surgical ward, 16 beds (based on data from 8 wards)

both types of single room						
efficiency of provision (%)	36	65	84	94	98	
efficiency of utilization (%)	95	86	74	62	52	
type-A rooms only						
efficiency of provision (%)	45	76	92	98		
efficiency of utilization (%)	87	73	59	47		

fig. 2

*"Single Rooms in Hospital: Estimate of the Medical Need." Goodall, J.W.D., (1951) *Lancet*, 1, 1063; "Early Ambulation: A Survey of Hospital Practice." Goodall, (1951) *Lancet*, 1, 45; "Cross Infection in Hospital Wards." Goodall, (1951) *Lancet*, 1, 807.

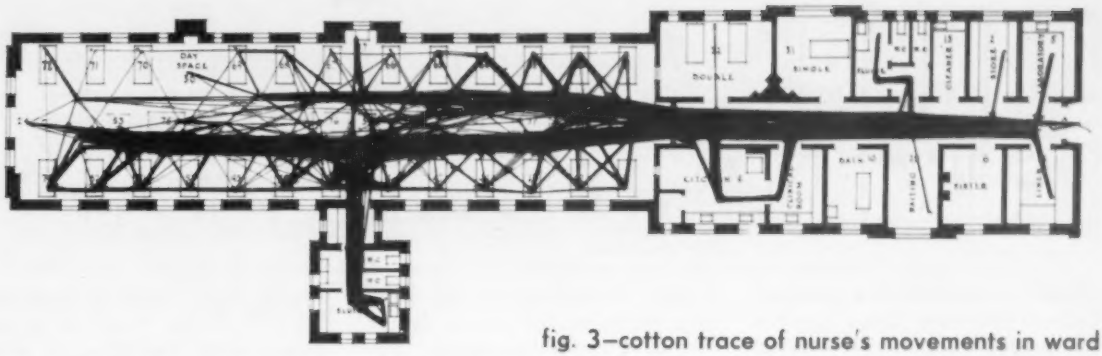


fig. 3—cotton trace of nurse's movements in ward

ment under which each nurse tends to have a job, such as temperatures, injections or bedpans, that she does for a large number of patients. We are making practical experiments in order to find the best size for the nursing and administrative units.

Studies of ARCHITECTURAL PROBLEMS were made by architect members of the team working in conjunction with scientists at the government's Building Research Station. They were concerned with natural and artificial lighting, heating and ventilation, the prevention of sound and fire and the use of color.

Lighting. Perhaps the most important was the study of daylight. The deeper a ward building is planned, the cheaper is the building and the shorter the journeys made by the nursing staff. We think the limiting factor is daylight; and we wanted to know just how deep a ward could be and still be well lit from its windows.

Previous studies in daylighting, largely carried out in connection with design of schools, had been limited to the consideration of light received directly from the sky. It was known that there was a certain amount of reflection from the internal surfaces of the room, but this was not taken into account in assessing the light expected in a room or in establishing standards for design. Our ward studies were planned to take reflected light into account, as well as direct light. They were carried out by constructing a large-scale model of a ward and making direct measurements of the illumination at various points in the model with photo-electric cells.

The results were of considerable importance, and not only to hospital design. They showed that, under certain conditions, the amount of light received at the back of a room might be seven to eight times that due to direct light alone; and that some of the current standards established for daylight factor were therefore unnecessarily onerous. They pointed to the close relationship between lighting characteristics of a room and the color scheme. It was found possible to measure the contribution made by each surface—walls, floor and ceiling—separately, so that this could be considered when designing a color scheme.

The value of carrying the window below the normal sill level down to the floor was also demonstrated, as was the effect of reflection surfaces outside a building. It was also shown that where large windows are used, an increase in window area does not produce a proportional increase in daylighting. This is because the window not only admits light but also allows it to escape. In fact, so far as internal reflection is concerned the window acts as a black wall, reflecting nothing.

The model was also used to investigate the characteristics of a range of window designs, and solutions were developed for use in our experimental building. Fig 4, below, shows one arrangement. Here, a horizontal fin or baffle is incorporated in the window about seven feet above the floor level. This baffle serves to cut off the brightest part of the sky from the patient in the bed nearest to the window, while permitting light to pass above to the center of the ward.

Noise. We have also been recording the noise in existing hospitals, and we are rather shocked by some of the results. Undoubtedly hospitals are very noisy, and we must try to make our new buildings quieter. Sound protection, however, costs money and the architect wants to know just how far he ought to go. Our studies tell him where noises originate and how loud they are. He also needs to know what noise level is tolerable in the ward before he can work out how much insulation he needs in the building. We are just planning a study of tolerable levels of noise; and here, at long last, we have come back to a subject that can

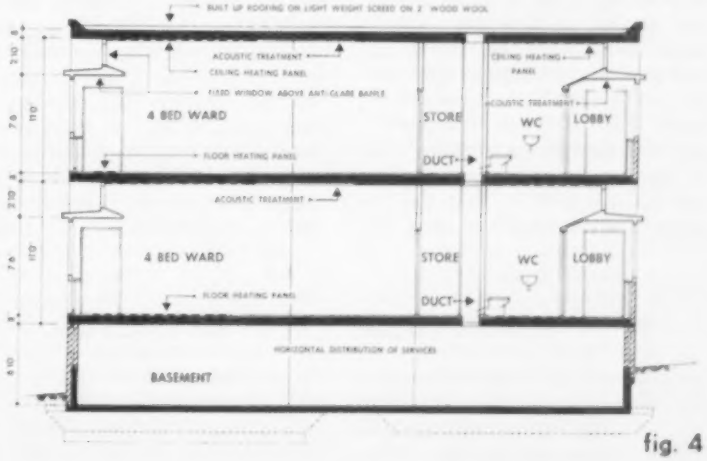


fig. 4

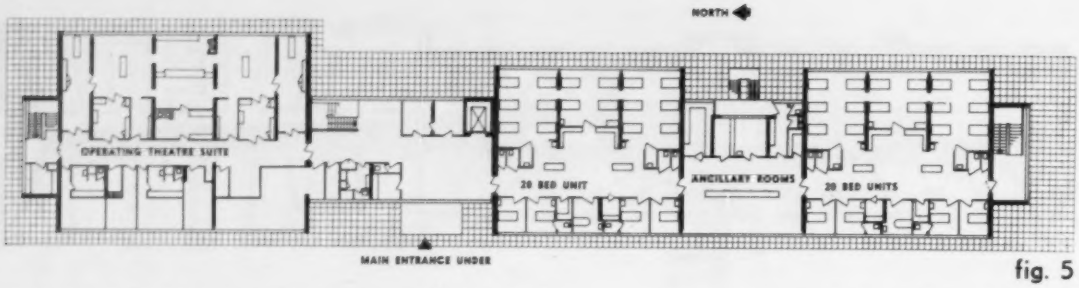


fig. 5

properly be studied by a questionnaire. If you want to find out what noises people can stand in hospital wards, the best thing to do is to ask them. Subjective research is appropriate here because the facts we want to get at, i.e., what noises people can stand and what they cannot, are themselves subjective.

APPLICATION TO DESIGN

These were some of the studies made by my team on a particular subject, ward planning; and I have described them in order to show you how a design can be broken down into a number of aspects each susceptible to research. Next comes the big problem of putting together the results and showing what they add up to in terms of design.

It is open to argument whether this is a proper task for a research body at all. In scientific research, the research worker is usually little concerned with the practical application of his results. He makes his research and publishes a full account of his methods and the results he achieves. The use, if any use is made of his work, he leaves to others.

I think that we should learn from the scientists to the extent of publishing full accounts of all our studies, in which we should describe not only the conclusions but also the methods. I think that we should publish accounts of work that has been unsuccessful or inconclusive, as well as that which has led to more positive conclusions. I think that the insistence on publication of a full account of method is a very valuable discipline. No scientist would dream of publishing a paper saying, "I have done a great deal of research on problem x and I have found the following answer". Yet this is what has frequently been done in the field of hospital planning. It would be far more useful to publish an account of the research and leave the reader to draw the conclusions.

We have endeavored to publish full accounts of our work as it proceeded, but we have also felt the need to take the matter one step further. We have felt the need to put together the results of a number of separate studies, and see what they led up to in terms of design. We have, in fact, designed and constructed experimental hospital buildings as a culmination of our research.

EXPERIMENTATION

The value of such experiments to a research team is enormous. It corrects the tendency to focus too closely on particular issues, a tendency which inevitably arises from the analytical approach. More important, it brings out the interrelationship of the different functional needs that a design has to satisfy. It gives a practical test as to how far new ideas have improved efficiency or cut cost. By arrangement with the hospitals, we are running trials for one or two years in each of our experimental buildings, and the results of these will be the verdict on our work. Without such practical trial, any research activities would soon become both sterile and academic.

Fig. 5, above, shows one of our experimental buildings, a ward block and theatre unit now going up in Northern Ireland. The ward plan reflects the research I have been describing, as interpreted in terms of British hospital practice. (It is important to realize that the very same research data, applied to conditions in another country—such as the United States—would result in a different plan.) The plan is based on a 20-bed nursing unit, four units totalling 80 beds being grouped to give an 80-bed administrative unit. (In the experimental project, there are two floors of 40 beds each, but in normal application there would be 80 beds on each ward floor, 40 beds on either side of the central stairs and lifts.)

Though basically derived from considerations of efficient working, this experimental plan also gives dramatic economies in construction cost. Comparing it with a 400-bed hospital using a conventional 25-bed ward unit, we have the picture indicated in Fig. 6, below. It is clear that the hospital using the experimental plan will be very much cheaper to build.

fig. 6

experimental plan	25 bed nursing unit
80 beds per floor	50 beds per floor
5 floors in ward block	8 floors in ward block
10 sets of ancillary rooms	16 sets of ancillary rooms

RESULTS ARE NOT 'STANDARDS'

Putting together the result of research in the design of an experimental building is not the same thing as the production of a type plan or a standard. We look upon an experimental design as one example—and one example only—of the sort of design that may arise as a result of research. We feel that the research data are the basic material. They can be interpreted in an infinite variety of ways to suit individual circumstances.

I do not think that it is any part of the work of a research unit to produce type plans or standards. This is not to say that I do not

(Continued on page 192)

facilities and equipment for isotopes program

G. W. MORGAN

LABORATORIES designed for the use of radioisotopes are similar, in most respects, to those used for other purposes. The special problems presented by radiation emitted by radioisotopes are twofold: (1) protection of personnel from external and internal exposure and (2) prevention of interference with radioassay analyses and radiation measurements.

These problems are resolved by modifying, and adding special facilities to, conventional laboratory plans. The principal consideration is the provision of sufficient space to permit segregation of the various laboratory procedures and effective use of the special facilities.

In the early period of the Atomic Energy Commission's radioisotope distribution program, many of the present refined techniques for handling and administering radioisotopes had not yet been developed. The facility requirements were not well defined and, for this reason, many laboratories were over-designed. But now sufficient experience has been gained to determine those facilities which incorporate adequate safety features at minimum expense. These practical features are discussed in this paper.

Before designing a radioisotope laboratory, it behooves all concerned to evaluate facility and equipment requirements in view of the proposed program. The degree of necessary laboratory adaptation and attendant special facilities and equipment depends upon such things as (1) type of radiation emitted by the radioisotopes, (2) level of activity, (3) type of manipulations, (4) chemical and physical form of the active materials, (5) volume of work and (6) number of people involved. Certain facilities and equipment are basic to all radioisotope work. For the typical hospital program, adequate equipment is available as standard items from supply houses.

Because different radioisotope programs may require different facilities, the design should provide sufficient flexibility to meet the need for expansion or change. The medical program, for example, often expands beyond initial expectations. In larger hospitals, or those associated with research facilities, the need may arise for use of radioisotopes in animal or radiochemical work. These possibilities should be considered in the initial plan so that the rooms can be grouped to conserve space and make most effective use of facilities and personnel. Although grouping of rooms is usually advantageous, in some cases it may be desirable to separate them, either for convenience or to insure a sufficiently low radiation background for counting equipment. Space requirements will vary from one room, for small programs in which isotopes are procured ready for administration to patients, to a three- or four-room unit for broad programs. The typical hospital unit, however, consists of two rooms—one for storage, dilution and dispensation and the other for uptake measurements and radioassay.

Three principal factors should be considered in selecting a laboratory location: (1) advantages from the standpoint of construction, (2) convenience and (3) instrumentation requirements. Location on the top floor simplifies the fume-hood exhaust problems. On the other hand, location on the ground floor or in the basement permits direct drainage of wastes into the sewer system. Also a basement location may simplify shielding problems, since load-bearing requirements are more easily met and since soil can often be used to shield outside walls. For the average laboratory, however, waste drainage and shielding problems are relatively simple and little preference should be given to a basement location solely for these advantages.

From the standpoint of convenience the radioisotope laboratory should be located near the supporting facilities, such as the clinical laboratory and the medical departments participating in the program. Accessibility to both inpatients and outpatients should not be overlooked, but areas of uncontrolled traffic should be avoided.

The requirements for technically acceptable measurements should receive prime consideration. To meet these requirements it is usually necessary to locate the counting and uptake-measuring room or rooms at some distance from x-ray machines, accelerators and areas where radium or other radioactive materials are stored or used in therapy.[1]

BASIC LABORATORY FEATURES

• FLOORS, WALLS AND CEILINGS

Floors of highly porous materials, such as wood and concrete, should be covered to minimize the possibility of contamination in case of spills. Paint provides some protection for wood or concrete, but more protection is needed since paint is neither very durable nor resistant to chemical attack.

1. See discussion under shielding (p. 104).

Mr. Morgan is chief of the Radiological Safety Branch, Isotopes Division, U. S. Atomic Energy Commission, Oak Ridge, Tenn. Material presented in this paper was prepared for the Committee on Use of Radioisotopes in Hospitals of the American Hospital Association.

Rubber, linoleum and various tiles, such as vinyl or asphalt, have proved to be suitable materials for this purpose. Asphalt tile is preferable for basements. Laying the floor covering in blocks, as with vinyl tile, has the advantage that if one block becomes significantly contaminated it can be readily replaced. For a well-controlled hospital laboratory, however, linoleum laid in the conventional manner is adequate. When flooring materials permit, the surface should be waxed, particularly at the cracks between adjacent blocks.

Walls, ceilings and woodwork should have a nonporous, washable surface from which radioactive materials can be easily removed. Walls of wood, concrete or cinder block need such protection, particularly at areas around sinks and behind work benches where contamination is most likely to occur. For a varied radioisotope program, it is considered good practice to cover such painted surfaces at critical points with special strippable coatings.

• BENCHES

Stainless steel bench tops are perhaps preferable, but—for the typical hospital program—ordinary laboratory benches are adequate if protected by appropriate paints. Such surfaces should be further protected by the use of trays to hold equipment where contamination is probable and to hold contaminated items, such as handling tongs. Work surfaces should also be covered with absorbent paper.

Benches, whether specially designed or adapted, should be sturdy enough to support the shielding required for gamma emitters. Cup sinks are recommended instead of the usual trough sinks since they are less likely to become contaminated. The usual utility outlets should be provided.

• SINKS

Ordinary stainless sinks prove adequate for most hospital radioisotope purposes provided they do not have rough surfaces. Enamel sinks should not be used when operations are likely to produce flakage, and attempts should be made to maintain smooth surfaces if existing stone sinks are used.

For large programs it is desirable to have both a double drainboard and a rack, for segregating and drying the glassware.

• SHIELDS

Shields serve both to protect personnel and to maintain a low radiation background for instruments used in assay and uptake measurements. Shielding requirements vary with a number of factors including the type and level of activity and the operations to be performed. In the construction and use of shields, problems of scattered radiation should be considered. An often overlooked fact in this regard is that the erratic pathways of beta particles in air may cause them to go over or around otherwise adequate shields.

The question often arises as to whether shielding should be built into the laboratory structure or whether the radioactive source or object to be protected should be shielded individually. Inasmuch as wall shielding offers no protection to persons in the room where the radioisotopes are used or stored, it is more desirable and economical to shield the sources individually or to build a barricade behind or within which manipulations can be performed. Structural shielding, on the other hand, can be used to advantage for unfrequented storage areas. In hospital work it is more convenient to use lead or iron bricks in constructing shields on benches and in fume hoods than to build in permanent shields. This provides greater flexibility.

As pointed out in the discussion under "LOCATION," the low radiation background requirements for technical measurements should not be overlooked. For health protection, dose rates should not be greater than 6.25 milliroentgens per hour[2] in areas normally occupied, whereas requirements for instruments may be about 0.01 mr/hr.[3] As in the protection of personnel, it is most economical to make maximum use of close shielding. That is, it is simpler to protect the counter tube or other sensitive element of the instrument by an individual shield than to add structural shielding to the walls. Protection by distance should also be utilized where practicable.

The relative effectiveness of shielding and distance may be illustrated by considering some specific examples. The exposure to counter tubes of gamma radiations from Iodine 131 (I^{131}) will be reduced by a factor of 90 by a one-inch lead shield or by a factor of 1,500 by a two-inch shield. To achieve the same reductions by distance alone, the distance between the source and the counter would have to be 10 feet and 39 feet respectively (assuming the initial dose rate measured at one foot). The same thickness of shielding produces greater reduction factors in the case of Gold 198 (Au^{198}), but for Cobalt 60 (Co^{60}) a two-inch lead shield gives a reduction factor of only 15.

The dose rate at the outer surface of storage facilities should not exceed 6.25 mr/hr. A distance of 25 feet would be required to reduce this to the 0.01 mr/hr level (when the distance from the source to the point of 6.25 mr/hr is one foot). If the stored radioactive material is Co^{60}, this reduction can be realized by shielding the counter tube with two inches of lead and moving it to at least seven feet away from the activity.[4] Patients who are undergoing therapeutic treatment with radioactive material should not be placed in rooms close to the counting or measurement room because of the possible influence upon the measurements being taken. This is especially true of patients who are being treated with Co^{60} or radium and to a lesser degree of those receiving I^{131} and Au^{198}. In many instances, inaccurate measurements can be traced to locally produced stray radiation affecting the counting equipment.

• STORAGE

Storage requirements will vary

2. For 48-hour week (7.5 mr/hr for 40-hour week).

3. Requirements may be more stringent for very sensitive instruments, such as scintillation counters.

4. This technical problem becomes much more acute when considering a location relative to x-ray machines or areas in which radium or Co^{60} is used in therapy. For example, assume that the dose rate outside the x-ray room is 6.25 mr/hr and that this point is ten feet from the x-ray tube. Under these conditions a total distance of 250 feet would be required to reduce it to 0.01 mr/hr. To so protect instruments from radiation emitted by 100 millicuries of Co^{60} or radium, respective distances of 390 and 300 feet would be necessary. However, if the counter were shielded with two inches of lead, the required distance would be reduced to 100 feet.

with the magnitude of the program, the radiation involved and the level of activity. A special closet for storage of radioisotopes and specimens is desirable, but when this is impractical, an area near the hood should be set aside for the purpose. For gamma ray emitters, a barrier shield should be constructed about this area. It is usually desirable to further shield sources individually within the barrier shields. Typical storage shields are shown in Fig. 1.

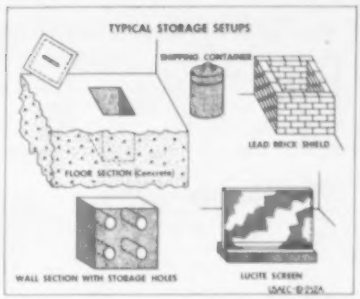


fig. 1

• HOODS

In radioisotope work, hoods serve to prevent contamination of the air in the laboratory from dispersed materials and to confine the activity and thus prevent contamination of work surfaces. Hoods are essential when radioisotopes are involved in such chemical processes as synthesis or in certain types of evaporation procedures. They are not required for simple dilution and evaporation procedures involving the types of isotopes and levels of activity most commonly used in diagnosis and therapy. In designing a new building, however, provision should be made for later hood installation if needed in an expanded program. When hoods are not required, it is sometimes desirable to install a window fan to provide ventilation in case of an accident.

Proper air flow characteristics are necessary for efficient hood operation. These characteristics may be obtained by (1) maintaining adequate velocities of air flow through the hood opening to prevent materials from escaping into the room and (2) designing the opening to minimize turbulence. The air flow characteristics should be determined for each hood, especially when ordinary fume hoods are used. Hoods designed specifically for radioisotope work are preferable to ordinary hoods (see Fig. 2). The rate of air flow in ordinary chemical hoods should be 75-150 linear feet per minute, while a rate of 50-100 linear feet is optimal for hoods for the design illustrated.

The exhaust blower should be located near the roof, rather than at the hood, in order to maintain a negative pressure in the ductwork and thereby prevent outward leakage. Blower motors should be mounted outside the ducts to avoid their contamination and make them accessible for maintenance.

The effluent should be discharged at a point where it will be adequately diluted before entering inhabited areas. (The possibility of contaminated air entering the hospital windows should not be overlooked.) The optimum height of the exhaust duct above the roof depends upon a number of factors. In general, minimum height should be five to ten feet.

• LOAD ON FLOORS, BENCHES, HOODS

Attention is called to the fact that lead barricade shields used for gamma emitters may weigh 1000 pounds or more depending upon the amount of shielding required.[5] Floors, hoods and other structures used to support shields should be sturdy enough to sustain this weight. Hood floors should be supported by steel girds. Unless weight requirements are known, floors of new buildings should be designed to support at least 150 pounds per sq. ft.

• PAINTS AND STRIPPABLE COATINGS[6]

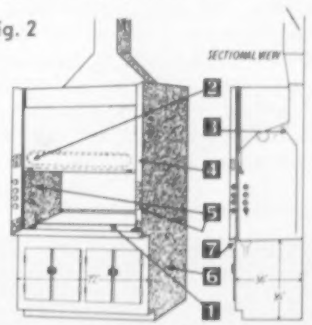
Paints of proven value should be used to cover all surfaces, such as the interior of hoods, with which radioisotopes may come in direct contact. Three coats should be applied, the first being a base paint capable of penetrating and sealing pores of the material. The second coat preferably should be a homogeneous extension of this coat. The third and surface coat should have low susceptibility to contamination and should be subject to easy decontamination. This final coat should be kept covered with wax.

• PLUMBING AND WASTE FACILITIES

Special plumbing is not required for disposal of wastes resulting from the radioisotopes presently being used in the typical diagnostic and therapeutic program. Wastes are disposed of directly into the sanitary sewer in accordance with recommendations of the Atomic Energy Commission and the National Committee on Radiation Protection. Special hold-up tanks are not required except in rare instances where hospitals located in small towns have very large therapeutic programs. Storage containers should be provided for solid wastes prior to disposal.

As with facilities, the required remote control and other equipment will depend upon the particular program. Specialized equipment and instrumentation are used for (1) laboratory handling procedures, (2) administering isotopes to patients, (3) assay and uptake measurements and (4) health safety. For handling materials in the laboratory, a variety of tongs and trays are needed. As previously mentioned, trays are particularly useful for confining activity and preventing contamination of working surfaces and other facilities. Typical equipment for handling

fig. 2



1. For proper fume control, all operations should be performed behind a safety line painted 8 inches inside the face of the hood.
2. For control of face velocity the lintel behind the sash contains an air by-pass opening.
3. Adjustable baffle for fume control.
4. "Picture frame" airfoil to decrease turbulence.
5. Utility outlets placed near the front to minimize hazard to operator when making a connection. Service handles and electrical outlets may be located outside of the hood.
6. Base structurally strong enough to support 1000 lbs. or more of portable shielding.
7. Vent space to improve air flow characteristics.

5. Often the uninitiated neglect to shield the bottom and rear of a barricade, thus exposing their legs, or persons below and in adjoining rooms.

6. A detailed list of useful paints and coatings suggested by the author can be obtained by writing to the editors of HOSPITALS, 18 E. Division Street, Chicago 10, Ill.

fig. 3

fig. 4

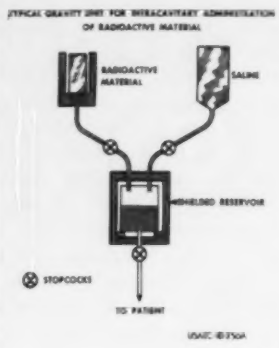


fig. 5

and transporting materials is illustrated in Fig. 3.

Specialized equipment is needed for intravenous and intracavitary injections of radioisotopes. Basic types are shown in Fig. 4 and Fig. 5.

The type of instruments needed for uptake measurements and for assay determinations will vary with the program. Geiger-Müller and scintillation counters are considered most suitable for diagnostic and therapeutic work. The former are more stable and simpler to operate, but scintillation counters are more sensitive to gamma radiations.

From the standpoint of health safety, instruments are used for personnel monitoring to determine the cumulative exposure to each individual, for quantitative measurements to establish permissible exposure periods and to evaluate the adequacy of shields and storage areas, and for qualitative measurements to scan surfaces for contamination.

Personnel monitoring may be accomplished with film badges or pocket meters of either the direct or indirect reading type. Film badges can be used to measure both beta and gamma radiation, while pocket meters are insensitive to beta radiation. Film badges are normally worn for a week and pocket chambers are read daily.[7]

Film badges are very useful where low-level exposure is anticipated, as in typical medical programs. Pocket chambers are useful for checking exposure during a single day or the performance of a specific operation.

Instruments used for quantitative measurements should have a measuring range up to 1,000-5,000 mr/hr. Those used for scanning surfaces should be capable of measuring dose rates of less than 1 mr/hr. The former measurements can be made with ionization chamber survey meters, instruments such as the "Cutie Pie" and "Juno," while Geiger-Müller meters are most useful for scanning purposes. For illustrations of typical instruments used for health safety, see Fig. 6 below. With future developments, instruments will perhaps be marketed with enough sensitivity to make all necessary survey measurements.

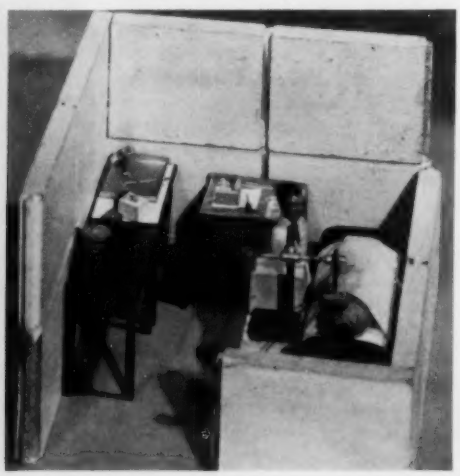
Facilities should be arranged to permit segregation of work, thereby minimizing the possibility of cross-contamination and permitting more accurate technical measurements. Space and room requirements will vary with the type and magnitude of the program. More space and facilities, for example, are required when radioisotopes are prepared, calibrated and sterilized in the laboratory than when they are procured in calibrated quantities ready for use.

To facilitate the handling of contamination problems in case of vomiting, patients should be kept under observation for a few min-

7. Film badge services are available from a number of commercial suppliers.

monitoring instruments—fig. 6

model laboratory for private practitioner—fig. 7



utes after oral administration of therapeutic dosages. A special waiting room may be required for large programs.

• SMALL HOSPITALS AND PRIVATE PRACTITIONERS

If the radioisotopes are secured from a commercial supplier in calibrated dosages and the program is small (as that of a small hospital or private practitioner), a one-room unit may suffice. One room 150-200 sq. ft. in area, as shown in Fig. 7 (p. 106), may be adequate provided the storage area is properly shielded. The problem of controlling the background for instrumentation purposes, however, may be serious. By using a portion of another room for uptake measurements and counting procedures, the size of this radioisotope room can be reduced to 100 sq. ft.

A private practitioner must have access to a hospital for care of patients treated with radioisotopes. He may desire to hospitalize patients treated with dosages of less than 30 millicuries, but hospitalization for health-safety reasons is required for all patients receiving dosages exceeding 50 millicuries. If hospitalization is required, the hospital must have facilities adequate for clinical care of patients and safe handling and disposal of radioactive materials. Also provisions must be made for instructing nurses. In some cases, the practicing physician may supply the equipment and direct the health-safety practices required for his program.

It is to be realized that exact facility and equipment requirements cannot be established, inasmuch as they vary with personal preferences and with the type and magnitude of the program.

• DIAGNOSIS AND THERAPY IN HOSPITALS

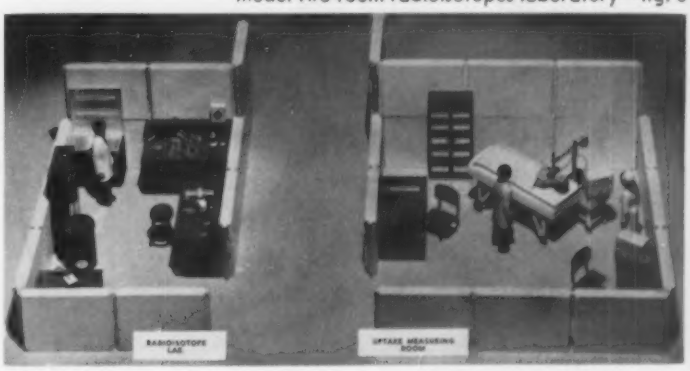
When isotopes are to be processed and dispensed, the radioisotope unit should have a minimum of two rooms. A high-level activity room is needed in which the radioisotopes may be processed and prepared for administration to patients. This room should have an area 150-200 sq. ft. if possible. As indicated earlier, it is desirable but not essential that it have an isotope storage closet. A second

table 1

suggested basic facilities and equipment when doses are prepared and calibrated locally

ITEM	NUMBER	REMARKS
I. LABORATORY FACILITIES		
A. FLOOR SPACE, SQ. FT.	150-200	Does not include counting room and uptake measuring area.
B. LABORATORY BENCH	2	High activity work. Low activity work.
C. FUME HOOD	1	Used in evaporation and other radioisotope processing.
D. SINK	1	Decontamination, liquid waste disposal.
E. RADIATION SHIELDING	25-50	Lead or iron bricks or other equivalent shielding.
F. PIPETTOR, REMOTE TYPE	1	Prevents workers' hands from entering radiation cone. Provides distance. Precludes mouth pipetting.
G. TRAYS	4	Secondary containers for contamination control. Recommend stainless steel or enamel.
H. WASTE CONTAINERS	1	Covered and posted with a warning label.
I STORAGE FACILITIES	1	Vault barricade and/or lead storage pots.
II. INSTRUMENTATION		
A. MEASUREMENT		
(1) Uptake	1	G-M or scintillation counter.
(2) Assay	1	G-M scintillation or ion chamber.
B. RADIATION SAFETY		
(1) Low-Level Survey	1	G-M or other sensitive type for monitoring bench tops, bed linens, etc.
(2) High-Level Survey	1	Ion chamber or other appropriate meter for surveying (5 mr/hr—5r/hr).
C. PERSONNEL METERS		
(1) Film Badges	1/person/week	Useful for monitoring both beta and gamma radiation. (See text).
(2) Pocket Meters	1/person	Useful only for monitoring gamma radiation. (See text).
III. RECORDS		
A. INCOMING SHIPMENTS	All	For compliance with federal regulations.
B. PERSONNEL EXPOSURES	Weekly	For compliance with NCRP and federal regulations.
C. SURVEY OF AREAS	Weekly	Routine weekly surveys and significant contamination events after each significant use.
IV. UPTAKE MEASURING AREA	1	See text.
V. HOSPITALIZATION	–	If patients contain over 50 millicuries of radioisotopes. Should be available for others if necessary.

model two-room radioisotopes laboratory—fig. 8



room is needed for uptake measurements and for radioassay in standardizing dosages and for analyzing specimens. Preferably, this room should have an area of 200-300 sq. ft. This two-room arrangement is illustrated in Fig. 8 (p. 107). For a moderate radioisotope program, three rooms are preferable so that uptake measurements and radioassay can be separated.

• DIAGNOSIS, THERAPY AND RESEARCH

When the program involves both high-level and intermediate-level work, as in research, a fourth room should be added (see Fig. 9). If the program expands to include the use of animals, other appropriate rooms should be added. Another room may be desired, for example, for the preparation of samples for counting, biopsies, etc. For expanded programs, still another room may be added for autoradiographic work so as to provide facilities for developing exposed films and storing photographic materials.

Tables 1 (p. 107) and 2 are included to serve as guides to basic requirements.

• POSSIBLE COSTS

An estimate on the cost of the different sized programs discussed above would be:

(a) Small hospital and private practitioners—$2,000 to $3,000.

(b) Diagnosis and therapy in hospitals—$2,000 to $4,000.

(c) Diagnosis, therapy and research—$3,500 to $7,000 or $8,000 and up.

The variation in cost is dependent upon the degree of utilization of existing space and major facilities, such as benches, and on the purchase of highly specialized instruments. ■

model four-room radioisotopes unit—fig. 9

table 2

suggested basic facilities and equipment when radioisotopes are procured ready for administration

ITEM	IODINE-131 DIAG.	IODINE-131 THER.	PHOSPHORUS-32 DIAG.	PHOSPHORUS-32 THER.	GOLD-198 THER.	REMARKS
I. LABORATORY FACILITIES						
A. FLOOR SPACE, SQ. FT.	100-200	X	X	X	X	See text
B. LAB. BENCH	X	X	X	X	X	
C. SINK	X	X	X	X	X	Liquid waste disposal, decontamination
D. RADIATION SHIELDING	–	Lead	–	Plastic	Lead	Lead or iron bricks, plastic for beta only
E. PIPETTOR						
(1) Remote Type	–	X	–	X	X	If individual doses are not prepared by supplier. Twelve inches or more in length
(2) Bulb Type	X		X			
F. TRAYS	X	X	X	X	X	Secondary containers for contamination control
G. WASTE CONTAINER	X	X	X	X	X	Covered and labeled "radioactive"
H. STORAGE FACILITIES	X	X	X	X	X	
II. INSTRUMENTATION						
A. MEASUREMENT						
(1) Uptake	X	X	X	–	X	G-M or scintillation counter
B. RADIATION SAFETY						
(1) Low-Level	X	X	X	X	X	G-M or other sensitive type survey for monitoring bench tops, etc.
C. PERSONNEL METER						
(1) Film Badge	–	X or	–	X	X or	
(2) Pocket Meters	–	X	–	–	X	
III. RECORDS						
A. INCOMING SHIPMENTS	X	X	X	X	X	
B. PERSONNEL EXPOSURES	–	X	–	X	X	
C. SURVEY OF AREAS	X	X	X	X	X	Routine weekly surveys, and significant contamination events
IV. UPTAKE MEASURING AREA	X	X	X	X	X	See text
V. HOSPITALIZATION	–	X	–	X	X	No patient containing 50 mc should be permitted to leave the hospital

X Item considered desirable
—Item not considered necessary

FLEXIBILITY IS ESSENTIAL AS WE—

design for future health needs

ALBERT W. SNOKE, M.D.

PLANNING THE DESIGN of a hospital based upon future medical needs is almost as difficult as planning for a superstructure on top of a foundation that is continually changing in size, shape and consistency. A hospital is designed to provide efficient, economical and pleasant care of the patient. The determining factors for planning the physical facilities must be the medical requirements and program of care.

When one reviews the past 50 years of medical progress with the revolutionary changes in thinking, philosophy, techniques, procedures, demands and emphases, and adds to this the profound economic and social changes that are still occurring to the individuals coming to hospitals, it is obvious that didactic prognostications based upon future medical needs may not only be foolish but futile.

With full recognition of the hazards of medical sooth-saying, one can only estimate as best as possible what the medical needs will be in the future and suggest planning construction in such a way that flexibility of future use is always paramount. Hospitals built today will probably be in use for at least the next 50 years, and thus must either lend themselves readily to changing requirements or become obsolete promptly.

AMBULATORY CARE

The increased trend toward emphasis on ambulatory care is already evident. The hospital is becoming more and more the health center of the community. Expensive and complicated diagnostic procedures are being concentrated in the hospital, and the physicians are referring their ambulatory patients to the hospital for diagnostic procedures not requiring hospitalization. X-rays, laboratories, health education classes, well-baby conferences, etc., are all becoming increasingly available to the patient upon an ambulatory basis, and facilities for these must be provided in the hospital. Emergency services are experiencing increased demand, as patients either come in directly or are referred by physicians rather than having the physician visit the home. Increases in diagnostic multiple screening programs and closer association of physicians' private offices with hospitals mean many more people walking through the hospital doors, seeking some type of medical advice, information or treatment but not expecting to be kept in a hospital bed. A complete hospital plan for the future should incorporate space adequate to care for these many ambulatory services.

EARLY AMBULATION

One of the most significant recent developments in medical care affecting hospital design has been early ambulation, with a resulting decreased stay of the patients. Patients are getting out of bed sooner after operations and are recovering from various infectious illnesses faster than 50 years ago. This decrease in hospital stay has played havoc with the old standards for special ancillary service facilities, such as operating rooms, delivery rooms, laboratories, x-ray departments, etc., as well as the design for hospital patient divisions. With a greater number of patients occupying the same number of hospital beds over a year's time due to a greatly increased turnover, all diagnostic and therapeutic procedures in the hospital are used much more for the same number of hospital beds than previously. This is particularly true of the operating suite, where increased turnover of surgical patients with longer and more complicated operations requires more operating room facilities per hundred beds than was the case in the past. Another example of the inaccuracy of previous standards is the need for more showers and more toilets on maternity divisions.

Dr. Snoke is director of the 716-bed Grace-New Haven Community Hospital, New Haven, Conn.

Obviously, the decreased length of stay, with the resultant increased turnover of patients, must approach an almost irreducible minimum; but it would be foolhardy to anticipate that level at this time. It is suggested, however, that much more attention be given to adequate facilities for the diagnostic and therapeutic departments of the hospital, with provision for expansion in the future based not only on the decreasing length of stay and the greater use of these facilities while in the hospital but also on the growing demand for the same facilities for the ambulatory outpatient.

PEDIATRICS

Pediatrics presents a striking example of change in hospital requirements based upon medical needs. The number of children requiring inpatient hospitalization is steadily shrinking. Experience throughout the country indicates steadily decreasing occupancy in children's convalescent units and general hospital accommodations. Children are being treated at home rather than in hospitals, as there are a greater number of well trained pediatricians and fewer children's diseases requiring prolonged hospitalization. Mastoiditis and osteomyelitis have had a dramatic reduction in incidence, as have had many of the infectious diseases. Rheumatic fever is becoming less common and the same may be happening to poliomyelitis within the next few years. All this requires fewer children's beds, smaller hospital pediatric units, greater flexibility in the use of hospital beds, and a corresponding increase in facilities for the ambulatory care of children.

Newer concepts of the needs of the child in the hospital, such as the necessity for a homelike atmosphere, liberalization of visiting rules and allowing parents to remain with children in the hospital, are causing not only complete re-thinking of the medical and nursing staff but also re-planning of pediatric divisions to accommodate the parents and visitors comfortably and efficiently.

INFECTIOUS DISEASE

Infectious disease has already become an entirely different problem in hospital care. The old separate isolation pavilion or "pest house" is as extinct as the dodo. Isolation wards are rapidly becoming passé—not only because there are fewer patients needing to be hospitalized but because it has been found that separate divisions are unnecessary for the treatment of contagious disease except for a few highly contagious ones. The vast majority of patients with contagious disease can be cared for on ordinary general medical or surgical divisions if proper nursing and medical techniques of isolation are carried out. This provides the opportunity for more efficient use of beds, higher occupancy percentages, etc.

One difficulty facing hospitals today in the care of the infectious disease patient is convincing the public and the doctor of the safety of such a method of treatment. With proper technique and proper medication, it is the rare disease that presents any undue danger of cross-contamination. For example, it is difficult now to get cultures of *str. haemolyticus* from patients with scarlet fever even for teaching purposes—not only because there are so few cases of scarlet fever, but because those who do have the disease are kept at home. If they must be hospitalized, the family physician has already given the "wonder drugs," which usually eliminate the hemolytic streptococci from the throat before culture can be taken in the hospital.

MEDICINE

There are times when one questions whether or not adult medical patients are following the same trend as children and whether one can expect a decrease in the demand for medical beds. This is probably not so. The older patient and the patient with chronic illness are coming more and more to the attention of the general practitioner and the internist—cardiovascular-valvular cases may be decreasing due to decreased incidence of rheumatic fever, but cardiovascular-arteriosclerotic cases are increasing because there are more older people. Chronic pulmonary disease with such complications as *cor pulmonale*, which once was so rare, is now becoming much more common. Patients used to die of pneumonia and other acute respiratory infections. Now they are being saved to live longer but with a slightly damaged lung. Eventually, repeated insults will result in a pulmonary insufficiency, so that a new type of chronic invalid must be treated.

Tuberculosis of the lung and other complications of this disease are steadily decreasing. The closing of Trudeau Sanatorium is a dramatic result of this change. Decrease in the fear of having patients with tuberculosis in the general hospital, more public understanding of the disease, greater ambulatory and home care programs—all are tending to bring the tuberculosis patient back into the general hospital. With improved case finding and treatment, however, it is extremely probable that tuberculosis will be a negligible problem in the years to come. In the meantime, regular medical and surgical divisions should anticipate caring for tuberculosis patients just as they do any other infectious disease patient.

OBSTETRICS AND GYNECOLOGY

Shortened stay, early ambulation, rooming-in and "natural childbirth" are all materially changing the design for labor and delivery suites, and for obstetric and nursery divisions. Privacy in waiting rooms and labor rooms, opportunities for the husband to remain with the wife during the early stages of labor, and provision for the baby to remain with the mother during the postpartum stay are substantially changing hospital design. Judging from the almost missionary zeal expressed by most fathers and mothers who have shared the experience resulting from these innovations in maternity care, future hospital construction must take this into consideration.

Small nurseries are being recommended for improved newborn safety. They are more expensive to staff and provide less flexibility in the event of shortage of personnel, but all advice from students of this subject indicates that this trend cannot be ignored.

Experimental work is currently being done on small, possibly single, air-conditioned units for the newborn that may replace the

precision control of fluid flow
with just one hand!
You can start or stop fluid flow and adjust its rate as many times as necessary with the exclusive Cutter Safticlamp*...and *one* hand does all the work.
The Safticlamp, built into every Cutter expendable I.V. set at no extra cost, is practical, too. It can't get lost or misplaced, can't slip, break or damage tubing. And you can actually bend the Safticlamp *up to 130 times* and still have positive flow control.
Ask your Cutter Hospital Supplier for a demonstration. *T.M.
SAFTICLAMP
exclusive on
All Cutter I.V. Saftisets*
CUTTER
CUTTER Laboratories
BERKELEY, CALIFORNIA

larger nurseries. Data are not available to warrant conclusions at this time.

SURGERY

Changes in methods of anesthesia and in surgical technique have had a profound effect upon the number of patients passing through hospital divisions. Early ambulation and improved preoperative and postoperative care have lowered the length of stay markedly, thus enabling more individuals per year to occupy a hospital bed. This has resulted in an increased ratio of operating rooms per bed in an institution and has necessitated various types of nursing units to care for the increased load of acutely ill postoperative patients. Recovery rooms are almost a basic requirement in hospitals of any major size, and recovery divisions caring for the acutely ill patient for 24 to 72 hours after operation are being more frequently considered. These divisions require much more provision for piped oxygen, suction and available work space around the patient's bed than the ordinary patient division.

Modern surgery and anesthesia also enable the surgeon to do much more involved and detailed operations than in the past. This again requires more operating facilities than were heretofore regarded as necessary.

PSYCHIATRY

The realization that psychiatric care in hospitals is not limited to couches or padded cells is becoming more and more accepted by the medical profession and by the hospitals. General hospitals must plan on making available space for psychiatric care as part of their over-all structure. This means not only units that can be properly protected as security units, but also more facilities for the psychoneurotic, the confused patient and the patient who enters with true medical or surgical disease but needs psychiatric consultation and care.

The psychiatrists are being recognized as deserving a more important role in the everyday functioning of the general hospital. It seems inevitable that all general hospitals of even moderate size will need to provide facilities for both inpatient and outpatient psychiatric care.

There is also increasing recognition on the part of physicians and administrators of the patient as a human being, with legitimate fears, foibles and idiosyncrasies, and with a family which is quite properly concerned over his welfare. As a result, much more attention is being placed upon the humane and understanding handling of the patient and his relatives, on greater provision for areas of relaxation and privacy for patients and relatives. It has resulted in a loosening of many of the rigid rules of the hospital that were supposedly for the benefit of the patient but apparently were primarily for the benefit of the hospital staff.

A striking example of the effect on construction of a change in a hospital rule is the marked decrease in the size of waiting rooms necessary for visitors when restricted visiting hours are abandoned and an ad lib program instituted.

CHRONIC CARE, REHABILITATION

This is a growing field in medicine that needs particular attention in any future planning and hospital design. The increasing numbers of older people, the increase in chronic illness, the increased emphasis upon rehabilitation—all present problems to the hospital. New concepts in the treatment of these patients in hospitals must be accepted.

The patient is not acutely ill, yet requires most of the facilities of the general hospital, plus an understanding of the necessity for an environment of cheerfulness, mental and emotional support, re-education and sympathy. Chronic care for those patients for whom active, intensive rehabilitation can provide relief and improvement is a logical component of the acute general hospital. It is no less expensive than ordinary medical and surgical patient care inasmuch as personnel must devote just as much skilled time to this area. Facilities for recreation, group therapy and "home living" should be provided for these patients and, if possible, in a homogeneous group.

CONCLUSION

Today's planning for tomorrow's hospital is difficult at best. Flexibility of design for future change is essential, but this is hard to incorporate in areas bounded by steel, brick and mortar.

Factors affecting hospital design for the future include ambulatory care, early ambulation, change in medical requirements in all specialties, increased demands for chronic care and rehabilitation, and the growing concept that patients and their relatives must be treated with understanding, gentleness and kindness on an individual basis. ■

NOTES AND COMMENT

Learning to handle people

Learning how to handle patients is one of the primary requisites of an adequate physician. A physician is not a salesman, but like a salesman he must understand and be capable in his handling of people. This is often a rather upsetting idea, and often a threatening one to the young scientist just going into practice.

He is eager to have the world beat a path to his door, begging for the accurate scientific help he has been trained to give. Often he has come to scorn the methods of the older practitioner with his bedside manner. He vows his practice will include no misspent time with what he calls "neurotics," healthy or otherwise.

If he is in a specialty which is in great demand, or in an area without competition, he may complacently and profitably go along ignoring his patients as humans, but should he be competing against others who have a more mature and helpful understanding of people, he will soon either learn, starve or leave. — FRANKLIN G. EBAUGH, M. D., writing in the *South Dakota Journal of Medicine and Pharmacy*. ■

THESE ACCESSORIES AND SERVICE PARTS ARE NOW AVAILABLE FOR ARMSTRONG BABY INCUBATORS

ARMSTRONG X-4 (Nursery-Type)	ARMSTRONG X-P (Explosion-proof)	ARMSTRONG H-H (De Luxe-Hand-hole)
Armstrong X-4 Nebulizers for supersaturated atmospheres.	**Baffle Plate extensions.**	**Replacement Hand-hole sleeves** —in packages of 4.
Baffle Plate extensions.	**New Style Thermometer**— metal armored—rugged—to replace old style Panels and cut maintenance costs.	**Scales**—one will serve for several incubators.
Tilting Beds. Aluminum— tilts either end.	**Service Exchange.** A generous allowance on the trade-in of an old X-P for a new X-P.	**Foam Mattress** and Vinyl plastic cover to fit.
Foam Mattress and vinyl plastic cover to fit Incubator or Tilting Bed.	**AND,** as always, good service if you'll write us the details air mail. QUICK,—too.	**AND,** as always, good service if you'll write us the details air mail. QUICK,—too.
New Style Thermometer— metal armored—rugged—to replace old style Panels and cut maintenance costs.		
Service Exchange. A generous allowance on the trade-in of an old X-4 for a new X-4.		
AND, as always, good service if you'll write us the details air mail. QUICK,—too.		

THE WINNER of our "Indian Cobra Contest" will be announced in this magazine next month. Many fine answers received. Thank you.

Details and prices are available on any of the above

THE GORDON ARMSTRONG COMPANY, INC.

508 BULKLEY BUILDING

CLEVELAND 15, OHIO, U. S. A.

against staphylococci

This is an actual strain of *Staphylococcus aureus*, isolated from a five-week-old infant. Note extreme sensitivity of the organism to ERYTHROCIN—although it easily resists the four other antibiotics. This organism may be associated with *sinusitis . . . otitis media . . . tonsillitis . . . abscess . . . bronchopneumonia . . . empyema . . . carbuncle . . . pyoderma . . . bronchiectasis . . . furunculosis . . . pharyngitis . . . septicemia . . .* and *tracheobranchitis.*

for specific therapy against coccic infections...

Wide range activity against gram-positive pathogens—that's the story of ERYTHROCIN *Filmtab**. As you know, most bacterial respiratory infections are produced by staph-, strep- or pneumococci. *And that is the very range where* ERYTHROCIN *is most effective.* In fact, you'll find it more active against this group of organisms than many other antibiotics.

filmtab*

Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

against common intestinal flora

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect growth of the organism—while the other antibiotics show marked inhibitory action. Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to cause alteration in common intestinal flora—with an accompanying low incidence of side effects.

...with little risk of serious side effects

One reason is because the drug acts specifically. It destroys coccic invaders, yet doesn't materially change the normal intestinal flora. Thus, side effects are rarely encountered with ERYTHROCIN. Nor does it cause the allergic reactions occasionally seen with penicillin. Abbott

filmtab*

Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

*TM FOR ABBOTT'S FILM SEALED TABLETS, PAT. APPLIED FOR

503333

planning for maintenance

A. D. BARNES

EQUIPMENT AND MEDICINE and techniques have changed, and so have ideas concerning the fundamentals of planning and plant layout. The engineer, however, still has to keep steam in the sterilizers and the laundry and see that the traps function properly. He still has to see that lines are tight and see that the power plant manufactures steam in an efficient manner. The engineer has the responsibility of seeing that the lighting and power distribution is successful in supplying service 24 hours a day. The engineer is responsible for maintenance of the physical plant —the repairs to broken plaster and the redecorating, the screens on the windows that must be in place, the roof leaks that have to be repaired. The engineer must see that the plumbing is in order, that the fixtures are in good condition or replaced if necessary.

You all are familiar with the many maintenance jobs in the hospital; and you know also that, as time marches on, the jobs become more numerous and perhaps more extensive. Therefore, it occurs to me that one way to plan for good maintenance is to consider the engineer's job and what he will have to do in the years ahead to keep the plant in satisfactory condition.

People are going to take care of the new hospital some day, and they won't be engineers, either. In fact, it is quite probable that many of them in the maintenance force will be totally inexperienced, and that the other staff personnel will be in a similar category. The engineer won't be able to hire qualified service men to operate his highly specialized mechanical equipment, the automatic elevators, pneumatic tube systems, electric-eye operated doors and all the rest of the items in a modern plant. He will have to train his men on the job and try to keep them from making mistakes—no hospital, or few of them, pay or are able to pay prevailing rates for qualified personnel.

The reason why I mention this is that architects and engineers who design hospitals and equipment and installations should be prepared to recommend plants that people can operate; or if it is necessary and desirable to include the latest developments in equipment, then I say they have some responsibility to see that the hospital authorities are advised that additional qualified personnel will be necessary to keep the plant in order. Too many times, a salesman or consultant recommends equipment without a thought of any responsibility after installation is made. That is not true of most reputable manufacturers, however, for they do follow up their equipment and are generous with their advice and assistance.

The basic and fundamental considerations in planning for good maintenance can be summarized under such headings as these:

1. Adequate space for engineering and maintenance activities—repair shops, storerooms, personnel locker rooms.
2. Power equipment for shops and grounds and housekeeping.
3. Central location for shops.
4. Geographical layout of plant —location of power plant, laundry and other services.
5. Systems and equipment to be gauged and valved to provide a knowledge of what is going on, and give maximum flexibility of operation.
6. Materials and finishes to be selected having in mind not only the type of service to which they will be subjected but also the ease of maintenance and eventual repair.

ADEQUATE SPACE

I am certain that in any planning for new hospital facilities the major thoughts are given to those for patient care; and, that of course, is as it should be. A hospital is primarily for patient care

Mr. Barnes is administrative engineer of the 1,042-bed Johns Hopkins Hospital, Baltimore, Md. This paper was delivered by the author to the American Hospital Association's Institute on Hospital Planning, Washington, D. C., in February 1954.

for ACCURATE TEMPERATURES · ECONOMICAL OPERATION · COMPLETE SAFETY

JOHNSON AUTOMATIC TEMPERATURE CONTROL

St. Joseph Hospital, Mankato, Minnesota. Gilbertson & Hayes, architects, Minneapolis; G. M. Orr Engineering Co., mechanical engineers, Minneapolis; Hutter Construction Company, general contractor, Fond du Lac, Wisconsin.

Few features for the modern hospital offer you so many opportunities to increase the efficiency of your operations as an Automatic Temperature Control System by Johnson.

By insuring just-right temperatures for every purpose, Johnson Control promotes faster recovery and greater comfort for patients. This assurance leaves the staff free to concentrate on technical duties—and with added energy!

Hospital management, while primarily concerned with patient welfare, also looks to precision control of temperatures and humidities for still another essential service . . . obtaining the greatest return from every dollar spent on heating or cooling. In addition, Johnson Control meets the most exacting safety requirements. *Pneumatically operated, it is completely safe, even in the presence of explosive anesthetic gases.*

At St. Joseph's Hospital in Mankato, an up-to-the-minute system of Johnson Automatic Temperature Control insures optimum temperatures and humidities at all times in the air conditioned operating suite, delivery rooms, nurseries and other vital areas. Strategically located Johnson Thermostats also maintain patients' rooms at the prescribed comfort level. An important fuel saving feature is the special Master-Submaster Control that varies the temperature of the hot water supplied to the heating system in accordance with outdoor temperatures.

Like *every* Johnson System, this installation was designed specifically to meet the particular requirements of each individual area in the building and insure the ultimate in efficiency, comfort, convenience and economy.

Any hospital, new or existing, can enjoy these same advantages. Whether your problem involves a single operating room or an entire hospital, ask an engineer from a nearby Johnson branch to explain the many desirable features and economy of Johnson Control. There is no obligation. JOHNSON SERVICE COMPANY, Milwaukee 2, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

TEMPERATURE AIR CONDITIONING

PLANNING • MANUFACTURING • INSTALLING • SINCE 1885

or for research which will improve patient care. I also believe that too many times the fact is overlooked that if these facilities are to function at their best, it must be made possible for engineering and housekeeping to contribute their best efforts.

Best functioning is not possible if engineering does not have space for shops and, just as in industry, suitable equipment with which to service the shops. It is not possible unless housekeeping has facilities for cleaning personnel, including lockers, storage, and rubbish room space. There should be a slop sink on every floor so that mops and water and supplies do not have to be moved from floor to floor. Services will be performed more efficiently if adequate space is available throughout the plant.

POWER EQUIPMENT

The days of the mechanical handyman and his tool box are gone forever, for hospitals have become mechanically-complex industrial plants. When a machine and an operator can do the work of two or more employees, it is a matter of simple economy to have the machine and the facilities to use it. Therefore, the shops should be provided with proper equipment, including work benches, test panels, power tools and storage and locker spaces.

The modern housekeeper should be provided with mechanical scrub machines and polishers and vacuum cleaners. Strangely enough, there are hospitals that do not have electrical outlets conveniently spaced so that her equipment can be used conveniently. It's a simple thing but vital. I am certain that this situation is being corrected in new planning.

CENTRAL SHOPS

We know that most every department in the hospital wants to be centrally located but that some department does have to be at the end of the building. I submit this request for a central location simply because an emergency telephone call from a supervisor —that the toilet is running over or the lights in the emergency room have gone out—will get much better service if the engineering department does not have to respond from a power plant half-a-block away, or perhaps from an adjoining building.

GEOGRAPHICAL LAYOUT

There is not sufficient time to go into all the considerations entering into the physical layout. Let us consider, however, a larger structure where there are prevailing winds and particularly a location where the climate is rigorous. There are many days, as you all know, when the side of the building away from the wind is very comfortable without heat, but the good people on the windward side of the building demand it.

We do not want to turn on the steam or start the hot water circulators to pacify the folks who are cold and make those on the other side of the building so warm that they eventually open the windows. In that case, the fuel consumed in the power plant is only being half used. The solution, of course, is to zone the building and provide proper heat controls. I believe that the increased cost will be made up by more economical fuel bills.

Windage is another consideration sometimes overlooked. You all have experienced occasions when you have difficulty opening the door to enter the building, and as much difficulty opening the door to leave it. If that condition will be met, a suitable foyer should be provided in the plan. After the building is constructed, it not only will be more costly to protect the lobby from the icy blasts when someone does get the door open, but it may be necessary to make an installation that obviously will be the correction of an oversight. It is a little thing, but the little things are the determining factors in your performance, as well as mine.

SYSTEMS AND EQUIPMENT

I have never seen steam systems, hot or cold water or plumbing systems with too many valves, but I have seen a lot of them with too few. Valves cost money, and the mechanical engineer designing the piping layouts always has the pressure on him to keep down the costs. He engages in hopeful thinking when he eliminates a cut-out valve here and there in the belief that perhaps it won't be needed. Actually, there will come a day when the services on the building are interrupted to make a new connection or to replace a section of pipe. That is the day the engineering department wonders who designed the system and those whose services have been interrupted wonder what is wrong again in the engineering department.

As for plumbing systems, I can spend hours citing reasons why the maintenance engineer wants the architects and designing engineers to specify waste lines to be twice the capacity they think will be necessary to do the job, and why the fall should be double the code requirements. There will come the day when two more stories will be added to the building, and someone will want to install a kitchen with a garbage disposal unit and dishwashing machine where there was originally a lab. The 2″ lines simply won't be agreeable—even if the code was. I know that none of us can foresee these things, and that there are practical limitations in all design and planning; but I do recommend that the designers be as generous as possible in considering needs for the new building.

Lighting fixtures frequently are beautiful to look at and may be most efficient, but they can be a real headache for the housekeeper to clean. Sometimes, also, it takes —as the Navy puts it—"all hands and the ship's cook" to replace a lamp because of inaccessibility of the fixture or difficulty of removing the shade. I believe the maintenance team will prefer a fluorescent fixture with the egg-crate louvre rather than the plastic shade, if the fixture is suspended. I know the lamp changer prefers a hinged louvre or shade when he has to change the lamp—for obvious reasons.

Plumbing fixtures and other fixtures that are wall-hung will simplify the housekeepers' and janitors' jobs. This type of installation presents the floor cleaner with a solid unblocked area of floor, without the "behind-the-fixture" spots which too frequently do not get cleaned. Since cleanliness is the largest single maintenance expense, as established for today's

Mayo Clinic Diagnostic Building, Rochester, Minn.
Architects: Ellerbe & Company, St. Paul and Rochester, Minn.
General Contractor: O. A. Stocke & Company, Inc., Rochester, Minn.
Acousti-Celotex: Insulation Sales Co., Minneapolis, Minn.

QUIET...just what the doctors ordered!

Noise slows down staff efficiency as well as patients' recovery. The cure? Acousti-Celotex Sound Conditioning. That's what the doctors of the Mayo Clinic prescribed for their beautiful new Diagnostic Clinic—and results were even better than anticipated.

Economy With Variety—At surprisingly low cost, a total of 187,175 square feet of the Diagnostic Building was given acoustical treatment. Where frequent cleaning was important, Acousteel* was installed. Where *washability* and *paintability* was a consideration, Acousti-Celotex Incombustible Perforated Mineral Fiber Tile was chosen—as on the ceiling of the Records Room above.

In wall treatment, as shown above, Celotex perforated Asbestos Board was used, over a sound absorbing element. For areas needing smart decoration, Celotone*, an incombustible fiber tile with rich, deep, sculptural effect offered the ideal surfacing. In elevator lobbies, for instance, it was spray-painted a soft, restful green.

*Reg. U. S. Pat. Off.

The Result: *Quiet* Efficiency—Everywhere, these applications control distracting sound at the source. Quiet replaces the routine noise of clinic activity, an irritation-removing quiet that benefits staff and patients alike. *Quiet comfort* that boosts morale, efficiency, and healing is the result of Acousti-Celotex Sound Conditioning. No special maintenance is required.

For Your Problems—No matter what the project . . . whatever the requirements of acoustics, building code, or design itself . . . your local Acousti-Celotex distributor is ready to assist you. His training, backed by the world's most experienced acoustical organization, can help you solve your specifications problem. For details, write The Celotex Corporation, Dept. F-35, 120 S. LaSalle Street, Chicago 3, Illinois. In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec.

Products for Every Sound Conditioning Problem

TRADE MARK

ACOUSTI-CELOTEX
REGISTERED U. S. PAT. OFF.
Sound Conditioning

THE CELOTEX CORPORATION, 120 S. LA SALLE ST., CHICAGO 3, ILLINOIS. IN CANADA: DOMINION SOUND EQUIPMENTS, LTD., MONTREAL, QUEBEC

commercial building, and represents 40 cents out of every dollar, we can assume it is of similar proportion in the hospital and worthy of every consideration.

HOUSEKEEPING

I am going to quote from an article in the January 1954 issue of *Buildings*. These statements are based on 22 years of experience of New York City's largest cleaning contractor, employing some 1,100 workers in some 1,500 buildings and offices:

"Terrazzo flooring is best for entrance lobbies, elevator corridors and public space of a building. Composition flooring, if not properly done, can constitute a slipping and accident problem.

"Covered floors are always better, cleaning-wise, than raw concrete or wood. Concrete should be treated with a sealer and will require less patching if so treated.

"For office usage, linoleum is the easiest type of composition flooring to maintain and simplest to wax with safety. In contrast, asphalt tile is tougher, easy to maintain, but presents a greater slipping problem after waxing.

"Floors which have to be washed should be surrounded by a 6" high base board at the foot of the wall.

"Steel panel partitions are easier to clean than wood. Smooth surface walls with a washable paint are easiest to clean.

"Swivel windows are more difficult to clean, even though the worker does not have to climb on the ledge.

"Flush door frames are easier to clean than those which buck out from walls."

ACCESSIBILITY

The importance of accessibility for maintenance is allied with the importance of layout. In a utility room in which both clean and dirty work in connection with patient care is carried on, for example, it certainly is not desirable that the bedpan sterilizer, ice chest, hopper sink and clean linen stand in adjoining spaces. When the plumber reports to repair the bedpan sterilizer, he does not want the nurse who is putting ice in the water pitcher to interfere with his work any more than she appreciates the plumbers' tools on the table from which she will issue clean linen. I am sure it is obvious why equipment must be installed in areas that are compatible with their other functions, and also that there must be room enough to service that equipment.

One only has to be experienced in maintaining older buildings to know the value of having pipe shafts and tunnels of generous dimensions, and I am sure that this practice is most often followed if possible. The design of some buildings to include the service facilities for adjoining bays insures for the life of the building that services and facilities always will be accessible; that, too, is an accepted practice.

CONCLUSION

In final analysis, I am sure I have merely confirmed your thinking, and that we as maintenance engineers all have similar problems. It is true, however, that mistakes continue to be built into new structures and, in a sense, it is the responsibility of the architect and mechanical engineer to see that they are not made. I know that the group concerned with the responsibility of providing a new hospital in the old home town may have a limited budget, and that when the estimates come in they are overwhelmed to learn that the funds are insufficient. Because of their unfamiliarity with hospital administration and operation, they start cutting corners by reducing facilities, the space allotted to various functions, the quality of construction and everything except the size of the structure and the number of beds. The architect, being only human and faced with the necessity of making a living, finally agrees, under pressure, knowing in his professional heart that it should not be. After all, he is working for the group, and they sincerely believe they know what they want. ■

NOTES AND COMMENT

Room conditioning cools iron lung

Recently, an air conditioning contractor asked the question, "How do you air condition an iron lung in the treatment of polio cases?" The question was sent to Dr. Philip Drinker of the Department of Industrial Hygiene, Harvard University, for reply, since he invented the "iron lung." Dr. Drinker asked the manufacturer of the "iron lung" to answer the question and was given a reply as follows:

"I think the best answer is to put it in an air conditioned room. Then the doctors and nurses can also benefit from the more comfortable environment.

"Actually, the temperature and humidity in an iron lung approximate very closely the conditions of its surrounding atmosphere, because the iron lung is self-ventilating. In other words, each time the bellows goes down, it creates a partial vacuum in the chamber to make the patient inhale and at the same time it also draws in a certain amount of room air. On the upward stroke, this mixture of air in the bellows passes through the chamber and out an exhaust valve—the chamber reaching atmospheric pressure during this cycle. Thus, room air passes through the chamber some 15 or more times a minute.

"About 20 years ago, we provided our iron lung with thermometers until we learned there was no appreciable difference in temperature between the inside of the lung and the room. On one or two occasions we provided a respirator with an air cooling unit, consisting of a large container of ice with a recirculating fan, and occasionally I have thought of adapting a window air conditioner for this purpose. It seems more practical, however, to air condition the room rather than the iron lung itself. Generally speaking, in my opinion, the temperature and humidity of an iron lung are no more uncomfortable than the same conditions surrounding a hospital bed."—WARREN E. COLLINS, JR., *writing in the April 1954 issue of* Heating, Piping & Air Conditioning. ■

Above: Laboratory; Below: Nurse's Station.

Here are views of the recently completed King's Daughters Hospital, Shelbyville, Kentucky. Architects: Nevin & Morgan, Louisville, Kentucky. Pharmacy illustrated above.

NEW
KING'S
DAUGHTERS
HOSPITAL

selects

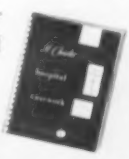
St. Charles

STEEL CASEWORK

Another impressive name is added to the long list of hospitals that are experiencing the many benefits of St. Charles casework. Architects have found that St. Charles long years of experience, competent personnel, and the nation's newest, most modern casework fabricating plant offer complete assurance of satisfying their specifications, from blueprint to reality.

St. Charles methods of custom-building and color styling place no limit on creative imagination, when you design and specify hospital casework.

To assist you in planning maximum efficiency into hospital casework, St. Charles offers a wide range of special units designed specifically for this demanding field. St. Charles also maintains a complete design and layout service, freely available to you in whatever degree you wish. Upon receipt of your enquiry, complete details will be sent you promptly.



A newly published, 40-page catalog, "St. Charles Hospital Casework," will be mailed to you when requested on your letterhead.

St. Charles

casework • sinks and counters • special purpose units

ST. CHARLES MANUFACTURING COMPANY, DEPT. H, ST. CHARLES, ILLINOIS

equipment and supply review

Dough retarder—salad refrigerator (3B-1)

Manufacturer's Description: This model features exclusive interchangeable interiors that are adjustable on one-inch centers to take any, or any combination of, bakers' pan slides, stationary or pullout meat rails, stationary or pullout shelves and biological drawers. Construction is 100 per cent all-metal with sanitary wipe-out bottom. Capacity of the unit is 40 cubic feet and a tray capacity equipped with 53 sets of slides. The front finish is

No. 4 polish 20-gauge stainless steel. Top, sides, back and interior are of corrosion-resistant aluminum. It has a 1/3 h.p. hermetically sealed unit. Width: 50¼ inches, depth 33½ inches, height 72¾ inches.

Background music service (3B-2)

Manufacturer's Description: A plan for the "lease-purchase" of background music and work music

services is now being offered to the smallest city, town or village. The subscribers make monthly payments that apply toward eventual ownership of the complete, high fidelity sound system, including speakers. The system provides automatic programming with no need for attendants. The system also provides for paging and public address service. The unit can be added to businesses already having sound and paging systems. The unit requires a minimum of table, desk or shelf space and is also available as a custom unit for built-in installations.

Motor-driven bed (3B-3)

Manufacturers' Description: This motor-driven bed has been approved by Underwriters' Laboratories, Inc., for use with oxygen administering equipment of the nasal and mask type and with half-bed length oxygen tents. It was previously approved by Underwriters' for use under normal atmospheric conditions, and now it is the first such

bed to be approved for use with oxygen administering equipment.

Stair cart (3B-4)

Manufacturer's Description: A new stair climbing hand truck, which is said to safely double the load a man

can roll up steps and treble the load he can move down stairs or ramps, has been announced. It is equipped with a special ratchet mechanism which enables it to roll up stairs, step by step, as the operator pulls a cable drive. Experimental models have proven practical for handling such items as barrels, drums, castings, welding tanks, etc. Features such as interchangeable shoes, sealed ball

To learn the names and addresses of manufacturers of products described in this review, simply clip, check the appropriate items on this coupon, sign, and mail to the Editoral Department of HOSPITALS, 18 East Division Street, Chicago 10, Illinois

- ____ Dough retarder—salad refrigerator (3B-1)
- ____ Background music service (3B-2)
- ____ Motor-driven bed (3B-3)
- ____ Stair cart (3B-4)
- ____ Demountable display unit (3B-5)
- ____ Crib fracture set (3B-6)
- ____ Magnesium roller conveyor (3B-7)
- ____ Food and water monitoring unit (3B-8)
- ____ Tubular surgical gauze (3B-9)
- ____ Folding commode (3B-10)
- ____ Plastic floor repair material (3B-11)
- ____ Utensil holder (3B-12)
- ____ Steel shelving (3B-13)
- ____ Resuscitation by air (3B-14)
- ____ Packaged air-conditioning unit (3B-15)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

...More and More Hospitals *Adopt* Aloe Contour Breast Pads

Late last fall, the Aloe Company introduced an entirely new shaped, absorbent breast pad. Now hundreds of hospitals in all parts of the country have adopted as routine this better way of handling the problem of excess lactation.

The experience of Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska, is an example of the acceptance of this remarkably successful product. Mr. Francis Bath, Business Manager, writes:

"...We believe that St. Joseph's was one of the earliest of the hospitals to use this breast pad in the maternity department, where it has won favor not only with the personnel, but even more among the patients. We have had several mothers who have taken home as many as six boxes..!

"Sister Mary Corneliana, O.S.F., O.B. Supervisor, is enthusiastic about the pad, as she finds it much more satisfactory than the sponges which were used formerly."

This shaped pad was one of those ideas the need for which had been felt for a hundred years or more, but about which little was done. Nurses and supervisors have always known that there must be a better way of stemming the flow of excess lactation in new mothers than that of using irritating gauze sponges, make-shift cut pads or lumps of cotton under the bra.

It takes hours of hospital personnel time to "manufacture" such improvised pads, and additional labor time to apply, with the results seldom satisfactory. Hospitals speedily recognized the obvious advantages of a prepared, scientifically designed pad, when we introduced it.

Aloe Takes No Credit for suggesting the shaped Breast Pad. Actually a physician friend of the Company decided that the time for such a pad was long overdue. Nature and common sense dictated the design. We merely placed the problem of production before an experienced manufacturer, with the stipulation that materials must be of the finest and that control of quality must be rigid.

The Natural Contour Shape and perfect absorbency of Aloe Contour Breast Pads are responsible for their instant acceptance. Anatomically formed to fit the breast with full coverage of nipple, areola and a generous adjacent area (3¾ inches in diameter), they are unobtrusive in appearance and afford complete protection to the patients' clothing. Patients, of course, overwhelmingly endorse them.

The Pads are made of cotton, filled with soft, highly absorbent cellulose —non-allergenic, non-irritating, helpful in preventing retracted and cracked nipples; a great aid in applying medication. They are packaged one dozen (average daily supply per mother) in an attractive carton; easy to dispense; labor saving; generally applied by the mother herself. Easy to store. They are disposable and therefore eliminate repeat sterilization. Patients usually want to purchase an extra supply from the hospital dispensary for continued use at home.

Among Aloe Contour Breast Pad users are:

Ball Memorial Hospital
Muncie, Indiana

Centro Asturiano Hospital
Tampa, Florida

Creighton Memorial St. Joseph's Hospital
Omaha, Nebraska

Good Samaritan Hospital
Sandusky, Ohio

Hutchins Memorial Hospital
Buford, Georgia

Lee Memorial Hospital
Fort Myers, Florida

Marymount Hospital, Garfield Heights, Ohio

McLaren General Hospital
Flint, Michigan

Mease Hospital, Dunedin, Florida

Mercy Hospital, Toledo, Ohio

Misericordia Hospital
Milwaukee, Wisconsin

Munroe Memorial Hospital
Ocala, Florida

Ohio Valley General Hospital
Wheeling, West Virginia

Passavant Memorial Hospital
Jacksonville, Illinois

Roper Hospital
Charleston, South Carolina

Self Memorial Hospital
Greenwood, South Carolina

South Carolina Baptist Hospital
Columbia, South Carolina

St. Anthony's Hospital
St. Louis, Missouri

St. Joseph's Hospital, Milwaukee, Wisconsin

St. Joseph's Mercy Hospital
Pontiac, Michigan

St. Luke's Hospital
Kansas City, Missouri

St. Mary's Hospital, Athens, Georgia

St. Mary's Hospital
Kansas City, Missouri

Tallahassee Memorial Hospital
Tallahassee, Florida

Tampa Municipal Hospital
Tampa, Florida

The Valley Hospital, West Point, Georgia

University of Kansas Medical Center
Kansas City, Kansas

Winter Haven Hospital
Winter Haven, Florida

If you have not seen the Pad, just jot your name on your hospital letterhead today. Sample and literature will be sent immediately.

A. S. ALOE COMPANY

AND SUBSIDIARIES

1831 Olive Street St. Louis 3, Mo.

LOS ANGELES • SAN FRANCISCO • SEATTLE • MINNEAPOLIS • KANSAS CITY • DALLAS
NEW ORLEANS • ATLANTA • WASHINGTON, D. C.

bearings and steel tube construction are said to assure load flexibility and a long efficient life. The truck is equipped with large pneumatic tires which add to ease of operation and eliminate any marking of steps. Six models are available for handling various sizes of loads, including a special barrel cart.

Demountable display unit (3B-5)

Manufacturer's Description: This unit consists of a panel 4 feet by 4 feet in one piece, or folding down to 2

feet by 4 feet. It is available in plywood, pegboard, and cork face. It includes a headboard, literature shelf, legs and a fitted shipping case. A smart lighting fixture with extension cord is also available at a small additional charge. The unit can be set up or repacked by one person in five minutes and is also available with two side panels. This unit would be excellent for displaying materials on the nursing school and on various hospital programs in the lobby or reception rooms for the public to view or for medical staff presentations.

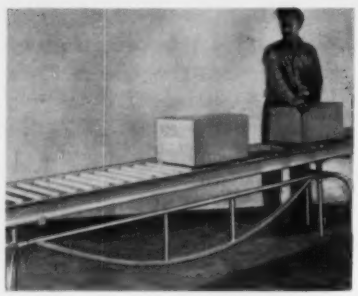
Crib fracture set (3B-6)

Manufacturer's Description: A new fracture set is available which can be used for all types of child trac-

tions. It fits any crib, metal or wood, and causes no damage to the crib. Some of its features are fast assembly, all angles of traction, swivel jointed pulleys, interchangeable parts, light weight and few loose parts. The set can be used for double Buck's extension, for single Buck's and cervical tractions and for Bryant's tractions.

Magnesium roller conveyor (3B-7)

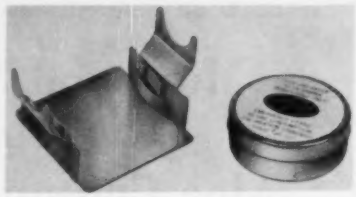
Manufacturer's Description: These new units are constructed entirely of magnesium, and weigh from 15 to 40 per cent less than comparable equipment of similar size and capacity. Suitable for permanent installation or for portable use, the conveyor can be easily set up or dismantled by one man, and greatly facilitates conveyor job spotting in plants and warehouses. Available in two capacities, 500 lb. and 900 lb. Roller sizes range from 12 inches to 20 inches. These units can be installed as a complete system or supplied in individual sections with couplers to match existing systems. Portable magnesium



stands in three height ranges, 17" to 72" above floor level, are also offered.

Food and water monitoring unit (3B-8)

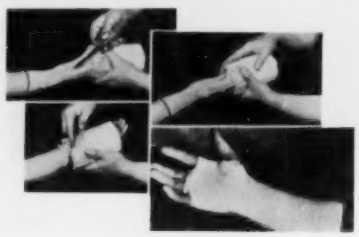
Manufacturer's Description: This is a simple, $10 device which makes it possible for hospitals, water companies, etc., to determine in seconds if their food and water supplies are contaminated following an atomic blast. The use of the unit is simple. First, a probe type monitoring instrument is used to measure the activity given off by a standard. Next, a small tin is filled with the suspected food or water, and the amount of radioactivity determined. If the activity is not greater than that from the standard, then the con-



taminated food or water can be used for ten days. If the activity is one-third or less, the food or water can be used for 30 days.

Tubular surgical gauze (3B-9)

Manufacturer's Description: Tubular surgical bandage that slips over any part of the body has recently been introduced. Made from double-bleached, highest-quality cotton yarn, it combines soft texture suitable for the lightest bandage with strength needed for tension. The gauze has many specialized uses, including wet dressings, collodion splints, ointment dressings and



pressure bandages. Spring and cage type applicators are available in ten sizes to suit all types of injuries from a small finger to a thigh or head. Additional layers of the bandage are added easily.

Folding commode (3B-10)

Manufacturer's Description: An attractive folding chair now converts to a sanitary commode in a matter of seconds. The chair has arm rests of aluminum with the backrest and seat covered with pearl plastic, in

LOS ANGELES' FAMOUS

Cedars of Lebanon Hospital

SELECTS SIMMONS...OF COURSE

The concept of a new Maternity and Pediatrics Building for world-famous Cedars of Lebanon Hospital demanded furnishings and equipment that would not only be the last word in efficiency and practicality, but would provide color, warmth and beauty as well. The selection was Simmons—of course.

Quality of workmanship and materials has been a Simmons byword for over 30 years. No other line of hospital equipment can match Simmons for efficiency and versatility—kept constantly up-to-date through ceaseless testing under actual hospital conditions. Yet, as shown above, the color, warmth and styling of Simmons Furniture form a sharp contrast to the cold institutional atmosphere usually associated with the word "hospital."

If you're planning new construction or refurnishing, see your Simmons Dealer, or write the nearest Simmons office for helpful advice.

Room shown above is from the new Maternity and Pediatrics Building, Cedars of Lebanon Hospital, which has been furnished completely by Simmons. Furniture is Simmons "152" Series in Silver Mist. Beds are versatile Simmons Vari-Hite, equipped with 3-crank springs and safety sides.

Contract Division

SIMMONS COMPANY

Display Rooms:
Chicago 54, Merchandise Mart
New York 16, One Park Avenue
Atlanta 1, 353 Jones Ave., N. W.
San Francisco 11, 295 Bay St.
Dallas 9, 8600 Harry Hines Blvd.

ROUTINE USE IN MILLIONS OF CASES HAS FIRMLY ESTABLISHED THE VALUE OF **UROKON®**

...first

Urokon Sodium Brand of Sodium Acetrizoate

...then

Urokon Sodium Brand of Sodium Acetrizoate

In the new COLOR-BREAK ampul

and now

Urokon Sodium Brand of Sodium Acetrizoate

MALLINCKRODT CHEMICAL WORKS
Mallinckrodt St., ST. LOUIS 7, MO.
72 Gold St., NEW YORK 8, N. Y.
Chicago • Cincinnati • Cleveland • Los Angeles
Philadelphia • San Francisco • Montreal • Toronto

Mallinckrodt®

UROKON SODIUM Sterile Solution 30%

—widely accepted for INTRAVENOUS UROGRAPHY (in routine cases), RETROGRADE PYELOGRAPHY and CHOLANGIOGRAPHY, following the first clinical evaluations by Nesbit and Lapides[1] and Richardson and Rose[2]—provides *adequate* diagnostic films with *minimal* side reactions.[1]

UROKON SODIUM Sterile Solution 70% (CONCENTRATED)

—for INTRAVENOUS UROGRAPHY (in difficult cases), ANGIOCARDIOGRAPHY, CHOLANGIOGRAPHY, TRANSLUMBAR ARTERIOGRAPHY, NEPHROGRAPHY and (in dilution) for RETROGRADE PYELOGRAPHY — was developed to extend the use of UROKON to special diagnostic procedures. It is recommended for intravenous urography *in difficult cases,* including obese patients, children under four, and the occasional "average" patient who does not afford adequate shadows with less concentrated media. It gives diagnostic films of *superior contrast* and the incidence of side reactions is moderate[3,4].

[1]Nesbit, R. M. and Lapides, J.: J. Urol. *63:* 1109 (1950).
[2]Richardson, J. F. and Rose, D. K.: J. Urol. *63:* 1113 (1950).
[3]Nesbit, R. M. and Nesbitt, T. E.: U. Mich. Med. Bull. *18:* 225 (1952).
[4]Zinc, O. C.: (Private report dated May 12, 1952).

...a new standard in Contrast media

UROKON® SODIUM

Sterile Solution 50% (STANDARD)
for
INTRAVENOUS UROGRAPHY (in routine cases)
May also be used for CHOLANGIOGRAPHY
and (in dilution) for RETROGRADE PYELOGRAPHY

Widespread experience with UROKON Sodium 30% and UROKON Sodium 70% led to the development of UROKON SODIUM 50% (STANDARD). This medium is applicable to a broader range of patients. Its *superb contrast* and *few side reactions* in routine INTRAVENOUS UROGRAPHY provide films of improved diagnostic quality for the doctor and maximum comfort for the patient.

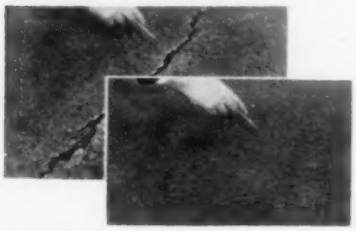
If you haven't used UROKON...
try UROKON SODIUM Sterile Solution 50% (STANDARD) FIRST.

30% · 50% · 70% Remember ALL THREE ARE AVAILABLE...MAKING UROKON EXTREMELY VERSATILE

a choice of rose, green or black. It cleans easily and folds flat for convenient storage. Priced at $35.

Plastic floor repair material (3B-11)

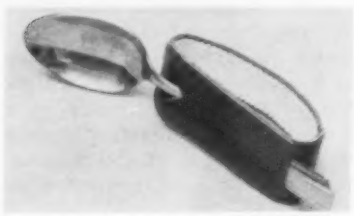
Manufacturer's Description: A new plastic material formulated for the



specific purpose of repairing floor cracks and preventing further surface deterioration is announced. The material can be applied without interfering with production or traffic and withstands heavy loads immediately. It is a fine granular, ready-to-use plastic product that readily fills hairline cracks, shallow holes, spalled floors or expansion joints. It contains no asphalt, cement, sand or gravel. The material will not crack, crumble or curl and can be applied either indoors or out, and is not affected by temperature changes. It is waterproof, dustless, skid-proof and noiseless. No mixing is required for this ready-to-use material, which is available in 5, 10, 30 and 55 gallon drums.

Utensil holder (3B-12)

Manufacturer's Description: A new utensil holder is being offered for use in rehabilitation programs and by disabled persons. It is intended to



hold a knife, fork or spoon, a toothbrush, rat-tail comb or razor. It simplifies and makes possible activities of daily living for the quadriplegic, the post-poliomyelitis patient, the arthritic person and others. It is composed of an elasticized webbing band made to fit over the hand and to which is attached a leather strip placed on the palmar side. Into such a packet formed by the strip can be placed any utensil such as mentioned. With very little practice the disabled person can become adept at a variety of activities.

Steel shelving (3B-13)

Manufacturer's Description: A line of steel shelving, with more than 1,000 different combinations that permit custom assembling of an installation for virtually all kinds of storage needs, is now available. The shelving comes with or without sides and back. The shelving is manufactured to such

close tolerances that components and assemblies are completely interchangeable. The shelving components include posts, side and back panels, shelves, full and partial dividers, bin fronts, braces, label holders and swinging and sliding doors. Shelves come in 35 different sizes from 24 inches by 9 inches to 48 inches by 36 inches. The shelves are of 18 gauge steel. Holes in the posts are on one-inch centers. Consequently, shelf heights can be varied from one inch to as large as desired.

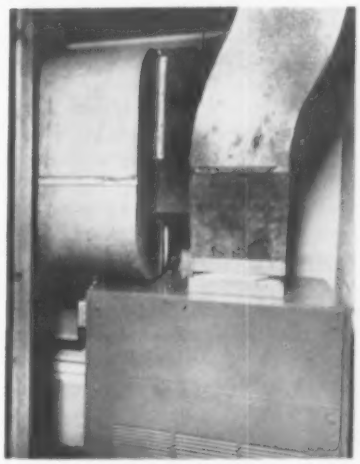
Resuscitation by air (3B-14)

Manufacturer's Description: A new concept of automatic artificial respiration is embodied in this unit. The unit is designed to operate from a fresh air blower and thus can be run off an electric current

of 110, 28 or 8 volts. Because the resuscitator can be so operated, its weight is less than ten pounds. It is well suited for ambulance, rescue squad and other emergency service because it can be operated by the current from a car or truck battery. The unique resuscitator valve is designed to operate on positive and negative pressure or on positive pressure alone. The unit is also available with an oxygen cylinder. This unit weighs 29 pounds and can be used with an air blower unit by means of a simple connection.

Packaged air-conditioning unit (3B-15)

Manufacturer's Description: Designed particularly for large spaces where water may be limited or there may be piping difficulties, these new units will be manufactured in four sizes from 2 to 7½ h.p. Installations requiring greater air-cooled capacity can be easily handled by multiple units. The air-cooled condenser can be installed on a roof or setback or even inside the building with ducts to supply outside air. The units will provide cooling,



dehumidification, filtering and circulation of air from a single compact cabinet. They may either be installed directly in the space to be conditioned, releasing air draftlessly through directional louvers, or distribute conditioned air by means of ductwork from a concealed location. Protecting the refrigeration and conditioning equipment is a rugged cabinet built of cold rolled steel, which is bonderized and coated with a rust-resistant primer and finished with baked enamel. ■

product literature

Following is a listing of pamphlets on equipment and techniques, available to hospital personnel free of charge. For other listings on the same subject refer to the February, 1955 issue of HOSPITALS. The coupon provided below should be checked to indicate those titles being requested. The manufacturer's name and address then will be sent to those requesting it.

Laboratory Equipment for Blood Centers by Hamilton—(BP3-1)—Booklet describing the Junior League Blood Center in Milwaukee and containing floor plans and elevations of equipment.

How to Plan a More Efficient Office–(BP3-2)

Softone, the Finish of a Scientific Search—(BP3-3)

How to Produce More Work by Sitting Down on the Job Correctly—(BP3-4)

Trends in the Office, Vol. 9, No. 1—(BP3-5) — Booklets emphasizing the importance of modern offices and equipment, and including description of new planning service.

Steel Storage and Display Equipment, Catalog No. C-RS1—(BP3-6)—Catalog of cabinets, shelving, counters and tables, lockers, parts bins, display storage and special equipment.

Catalog EC-2—Equipment for Modern School Laboratory—(BP3-7)

Sectional Laboratory Furniture — (BP3-8)—Catalogs on general laboratory sectional furniture, and on combination science desks, center tables, instructors desks and homemaking units for the modern school laboratory.

CBR by Kawaunee-AIA 35-E—(BP3-9)—Description of the designing and fabrication of equipment for chemical, biological and radiological laboratories.

Mills Metal Compartment Catalog — (BP3-10) — Describing the complete line of toilet compartments, shower and dressing rooms, shower units and hospital cubicles. Includes a color chart to aid in color planning.

Aerocor Insulations-GL6 C4—(BP3-11) — Description and illustration of various types of Fiberglas Aerocor Insulation, a complete line of thermal and acoustical insulations.

National Commercial Steel Boilers with Wing Induced Draft Fans—AIA 30 C-1 — (BP3-12) — Includes drawings of the fans and their component parts, charts detailing mounting dimensions and space requirements, and wiring diagrams.

Planning Construction Maintenance with Davidson Architectural Porcelain-AIA 15 H2—(BP3-13)—Six page catalog supplies general descriptive new double-wall panel for curtain-wall construction, and its flexibility to fit any type fenestration or spandrel system.

"Perimaheat" Baseboard Convectors by Young-AIA 30 C4—(BP3-14)—This catalog supplies general descriptive information and provides capacity data, selection procedure, method of installation, roughing-in dimensions and architectural specifications.

Porcelpanels-Porcelain Enamel on Steel or Aluminum-AIA 15H-2—(BP3-15)—A technical brochure including illustrations and architectural details for a number of buildings; specifications for porcelain enameled steel and aluminum; data on color, finishes; and a series of typical construction details.

What To Look For in a Good Translucent Building Panel—(BP3-16)—A simplified, concise outline of product standards for translucent fiber glass-reinforced panels.

Does This Happen In Your Hospital? —(BP3-17)—Description of a new individual room thermostatic control system which can be used with any type of heating system or window cooling unit, and is easily installed.

Young Air Conditioning Units-AIA 30 F2—(BP3-18)—This catalog covers fan performance data, heating and cooling coil performance, filter data, data on mixing boxes and physical and dimensional data.

Skytrol Glass Blocks for Toplighting your Buildings—AIA 12 J—(BP3-19)—Contains information on physical performance, technical data on light transmission, insulation values, installation drawings and complete specifications.

Celine Cold Cathode Lighting-AIA 31 F21 — (BP3-20) — Brochure explaining the cold cathode industrial lighting in a nontechnical manner.

Fenestra Hollow Metal Doors Swing and Slide — (BP3-21) — A catalog containing construction features, advantages, uses, installation instructions and specifications.

Here Are the Facts You Want to Know About Air-Conditioning an Entire Building with Individual Packaged Units—(BP3-22) — Documented report covering initial cost, operating cost, special problems relating to installation, operation, maintenance and performance.

Design Manual-Flexicore Split System of Warm Air Panel Heating—(BP3-23) — Technical assistance on a low-cost, panel convection heating system is offered in this manual. Examples of typical layouts are included.

Vokalcall Audio-Visual Nurses' Call Systems—(BP3-24)—A booklet describing the features and methods of operation of this system of bedside communication. Includes description of equipment of the various systems available.

IBM Nurses' Call System — Locking Button Type—(BP3-25)—Description of equipment of various types, including equipment layout diagrams. ■

To learn the names and addresses of manufacturers offering the pamphlets described in this review, simply check the appropriate items below, sign, and mail to the Editorial Department, HOSPITALS, 18 East Division Street, Chicago 10, Illinois

____BP3-1	____BP3-6	____BP3-11	____BP3-16	____BP3-21
____BP3-2	____BP3-7	____BP3-12	____BP3-17	____BP3-22
____BP3-3	____BP3-8	____BP3-13	____BP3-18	____BP3-23
____BP3-4	____BP3-9	____BP3-14	____BP3-19	____BP3-24
____BP3-5	____BP3-10	____BP3-15	____BP3-20	____BP3-25

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

to Mr. Purchasing Agent

FOR MAKING A WISE INVESTMENT

he switched to

ANGELICA "SAFETY-LOK"* SURGEON GOWNS

and needed fewer replacements

A farsighted P. A. can invest in the future — and come out with real savings. Hundreds have switched to Angelica "Safety-Lok" Surgeon Gowns and found Angelica's extra durability pays off in good hard cash. Look at these features:

(1) Exclusive "Safety-Lok" flap eliminates ties and provides comfortable fit. (2) Replacement of ties with indestructible cloth buttons reduces linen room repair costs. (3) Overlap in back provides complete sterility. (4) Durable re-inforced front yoke. (5) Raglan sleeves. (6) Permanently elastic, absorbent double-stockinette cuffs. (7) 54-inch finished length. (8) Tunnel belt — no loss, no repairs.

All Angelica Hospital Apparel is available for immediate delivery. Call your Angelica representative today.

*T. M. Reg.

Complete Line of Uniforms for:
DIETARY
MAINTENANCE
OPERATING ROOM
HOUSEKEEPING
PATIENTS
NURSING

Angelica® UNIFORMS

1427 Olive, St. Louis 3 • 107 W. 48th, New York 36 • 177 N. Michigan, Chicago 1 • 110 W. 11th, Los Angeles 15

Will the

THE DIETITIAN'S criterion for determining equipment and layout needs is the scientific analysis of meals to be served and work-hours required.

TO THE DIETITIAN planning a new food service department or remodeling an old one, selection and arrangement of equipment is one of the most important phases in programming. To meet the objective of good food service, planning should be a coöperative effort. "The person in charge of the food service, the administrator, the engineer, architect or consultant and others who are concerned with the planning should work together to produce the most efficient arrangements."[1]

The dietitian is the person familiar with and responsible for the operation and organization of the dietary department. Therefore she is the person best qualified to determine the dietary needs and to work with the team in all stages of planning.

The selection of the proper equipment to insure the best possible food service within the hospital budget deserves and demands more than mere guesswork or personal preference on the part of the program planners. It demands the scientific approach—what is the need and how is this need to be met.

Determining equipment needs for the new or remodeled dietary department begins with the planned menu. If it is a new food service department, administrative decisions must be made on the type of menu and the cost level of the menu to be served. Will the hospital provide a selective or nonselective menu? Is it to be a very choice, high cost menu or one planned on a low cost basis? Or will it be somewhere between these two extremes?

Other policy issues to be decided in a new hospital dietary department include the type of patient food service to be used, including the method of tray distribution, and the type of personnel feeding to be set up. Purchasing and storage policies also must be determined.

MASTER MENU

After the menu policy has been determined for the new unit, a typical master menu for one month for patients on general and commonly used modified diets is prepared. The American Hospital Association's Master Menu, published each month in HOSPITALS, can serve as a guide in preparing this menu. Many hospitals use the Association's menu series as their basic master menu with only a few minor changes and adjustments each month to meet local conditions.

If the dietitian is planning to remodel the department, the type and cost level of the menu are already established; the master menu is at hand; and the meal census for patients and personnel has been computed.

MEAL CENSUS

At the hospital already in operation, the accurate meal count[2] should be computed by counting the number of patient trays served from the central kitchen. In decentralized service, the tray count from each service kitchen is recorded. Infant formulas and nourishments served to patients between meals should be ignored in computing the meal census.

Meals served to personnel in the dining room or cafeteria is routinely obtained from the cash register reading or by the plate count, use of a mechanical counter or from a sheet on which the personnel sign for meals if a ticket system is not used.

In planning a new hospital food service unit, one can only estimate the patient meal census in light of the planned bed capacity and the anticipated per cent of occupancy. The pay policy greatly influences the estimated meal count for personnel. The present trend is toward the payment of a gross salary to all employees. In such cases, a larger number of hospital personnel may choose to eat most of their meals away from the hospital.

The next step in determining equipment needs is to select and extend recipes for each menu item to be served. This process will show the volume of food and space needed to prepare each menu item.

PROCESS CHARTS

A process chart of product through equipment is the scientific way of determining equipment needs for new or remodeled food service units. This system of product analysis portrays graphically the procedures and equipment necessary in the preparation of each menu item. A process chart similar to one shown for mashed potatoes in the illustration on page 132 is prepared for each item to be served.

Then a summary chart, a tabulation of each of the process charts

(Continued on page 132)

1. "Improving the Food Service," *Hospital Food Service Manual*, IX, (Chicago, 1954), 226.

2. *Food Cost Accounting*, (Chicago, 1948), 7.

equipment meet the need?

JOHN W. HARGRAVE

THE ARCHITECT, given the department's predetermined needs, contributes his special knowledge of engineering and equipment fabrication in working with the dietitian in the selection and arrangement of equipment.

THE ARCHITECT'S role in selection and arrangement of equipment is a two-fold job: to know the newest and best food service equipment available to meet the dietitian's predetermined needs, and secondly, to work with her in studying the simplification of functions to establish the best arrangement for the equipment.

A closer look at the new improved food service items available reveals five general trends in equipment construction and composition:

1. Emphasis on greater built-in sanitation in food service equipment.

2. Development and use of more portable food service equipment.

3. Use of the modular principle in developing food preparation, storage and service equipment and utensils.

4. Introduction of new systems of cooking and heating food.

5. Use of new metals and alloys in food service equipment.

6. Greater competition for the older established companies.

Sanitation standards for food service equipment, recently developed by the National Sanitation Foundation in coöperation with industrial and health officers, have led the way for greater simplification of equipment surfaces and cleaning procedures.

The NSF standards direct that the legs on equipment have closed feet and concealed height adjustments. Coved corners on interiors of drawers, sinks and bins, and elimination of all crevices too narrow to clean by hand also have been recommended. Enclosed spaces must be fully sealed against entry of vermin, or shall be provided with removable access panels.

NSF Standard 3.221 calls for range hoods or canopies with curtain walls or tile, metal lath and plaster, or stainless steel. Filters should be removable.

Sanitation codes for dishwashing machines provide for prevention of back-syphonage, complete drainage of wash tanks, more powerful and longer rinse sprays at hotter temperatures and automatic wetting agent dispensers.

PORTABLE EQUIPMENT

More and better portable equipment items are appearing on the market. Many of these items are of particular benefit to small hospitals. Several manufacturers have developed portable vegetable peelers (15-lb. size) and slicers, food cutters, steam cookers, fry and small tilting kettles and mixers scaled to meet the needs of the small hospital, but performing the same efficient job as the larger models.

Built-in lift-jacks and caster assemblies for floor-mounted electrical cooking units permit ease in servicing and cleanup. Portable pan and tray racks, generally made of aluminum, have been developed for use as dough proofers and pastry storage and pan cabinets. Made originally for shipping pastry products from central bakeries, these pan and tray racks have found wide acceptance in hospitals.

Small, portable, plate and cup rack dispensers with automatic counterbalances are now available. Light in weight, these dispensers will fit under counter tops or in small niches. They can be loaded in the dish pantry and delivered to the point of service without reloading.

Another new portable piece of food service equipment is the tray conveyor for hot and cold foods. Similar to the airline type of food service unit, this tray carrier stores hot foods in the heated compartment, while the balance of the meal is placed on the patient's tray and stored in the chilled section. Soups and hot beverages are stored in bulk in insulated containers and are served at the time the other hot foods are placed on the tray.

In the construction of the above portable items and in all types of food service equipment, an effort has been made to coördinate the size of the cooking, baking, storage and service equipment with racks, baker's sheets, serving pans and trays that will be used in or on them.

The two most common sizes in food service equipment are the 12 by 20 inch steam table pan and the 18 by 26 inch baker's sheet. Following the principle of modular coördination, ovens would be designed 26 inches wide (inside dimension) to accommodate two, 12 by 20 inch steam table pans on each oven rack. Steam cookers would hold one or two, 12 by 20 inch steam table pans on each shelf. Electric food warmers would be so designed to accommodate two, 12 by 20 inch steam table pans or one, 18 by 26 inch baker's sheet.

The fourth trend in food service equipment that I have observed

Mr. Hargrave is an architect, engineer and equipment consultant in Cincinnati, Ohio.

PROCESS CHART OF PRODUCT THROUGH EQUIPMENT

DESCRIPTION

PROCESS: Preparing Mashed Potatoes
Number of portions 100
☐ WORKER ☐ MATERIAL
CHART BEGINS: Potatoes removed from storage
CHART ENDS: Mashed potatoes ready to be served
CHARTED BY: M. E. Brown DATE: 1-31-55

SUMMARY

	PRESENT NO.	PRESENT TIME	PROPOSED NO.	PROPOSED TIME	DIFFERENCE NO.	DIFFERENCE TIME
Operation	6	92				
Transportation	4	6				
Inspection	22	4				
Delay						
Storage						
TOTALS	12	102				
DISTANCE		82 FT.		FT.		FT.

Distance in Feet	Time in Minutes	Operation	Transportation	Inspection	Delay	Storage	Std. No.	DETAILS OF PRESENT PROCESS / PROPOSED PROCESS	MEMORANDA Equipment Used
		○	⇨	□	D	▽		1. Potatoes in storage	
40	1	○	⇨	□	D	▽		2. Potatoes (33 lbs.) transported to vegetable unit	Hand truck
	3	○	⇨	□	D	▽		3. Potatoes sorted according to size	
	10	○	⇨	□	D	▽		4. Potatoes peeled mechanically	Potato peeler, electric
	30	○	⇨	□	D	▽		5. Potatoes "eyed" in water by hand	Work table and Sink
28	2	○	⇨	□	D	▽		6. Potatoes transported to vegetable steamer	
	40	○	⇨	□	D	▽		7. Potatoes cooked in steamer	Vegetable steamer
	1	○	⇨	□	D	▽		8. Potatoes removed from steam cooker	
12	2	○	⇨	□	D	▽		9. Potatoes transported to mixing machine	Hand truck
	10	○	⇨	□	D	▽		10. Potatoes mashed	Power mixer, electric
	1	○	⇨	□	D	▽		11. Potatoes seasoned	
	1	○	⇨	□	D	▽		12. Potatoes inspected and tasted for acceptability	
2	1	○	⇨	□	D	▽		13. Potatoes transferred to containers for service	
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			
		○	⇨	□	D	▽			

The dietitian

(Continued from page 130)

of the individual menu items, shows exactly the equipment required to produce the meals and indicates the size equipment that will be most satisfactory. This summary chart shows all menu items, serving portions required, equipment desired, including size, capacity and attachments, the length of time each equipment item is used for each product and the containers or utensils to be used.

Having scientifically determined equipment needs by checking the menu through the equipment, the dietitian is now ready to work with the architect and food equipment consultant on the selection of equipment available and the most efficient layout of the items selected. ■

The architect

(Continued from page 131)

is the introduction of new methods of cooking and heating foods. Infra-red heat lamps are being used for both roasting and warming products.

In electronic cooking, food cooks from the inside out almost instantly without heating the oven

or dish containing the food. At a recent exhibition, frozen casserole dishes were cooked in less than two and one-half minutes. The manufacturer of the electronic cooking equipment emphasized that this item is a supplementary tool, and does not replace conventional cooking methods.

USE OF NEW METALS

There has been a decided shift in the use of metals in food service equipment. There are four main reasons for the changes:

1. Desire for corrosion-resistance. Sheet metal sinks made of galvanized steel had a life expectancy of 10 years. Monel metal sinks made in 1920 are still in use. Stainless steel became a competitor when it was demonstrated that it had a slightly better resistance to certain food acids and had a brighter lustre than monel metal.

2. Desire for damage-resistance. Porcelain enamel and agate utensils are considered unsafe when the coating is damaged. Aluminum and stainless steel utensils resist breakage.

3. Desire for simplification in the maintenance of the equipment. Retinning of copper and steel utensils and nickel and silver plating were a large part of the early food service equipment business. Any utensil or piece of equipment which was overheated had to be resoldered—a costly operation in repairing coffee urns and similar hot food units.

4. Enforcement of sanitation regulations. Managers of public feeding establishments have demanded equipment designed to meet sanitation standards, and the food service equipment industry has responded through the selection and fabrication of better materials.

Today there are many types of alloys and metals used by the food service equipment industry. For example, type #302 stainless steel is nonmagnetic, keeps a bright lustre and has reasonably good resistance to most food chemicals.

Type #430 stainless steel is magnetic, darker in color than type #302 when it is exposed to the air, and is not recommended for direct contact with vegetable juices, hot vinegar, beer, mayonnaise or salt water. It pits readily if it is left

Here's a wonderful, sweet dessert that's sugar-free!

D-ZERTA

the new, flavored low-calorie gelatin

Your patients will love D-Zerta Gelatin. It's delightfully sweetened with saccharin, and comes in *six* flavors (the Jell-O flavors *everyone* knows)!

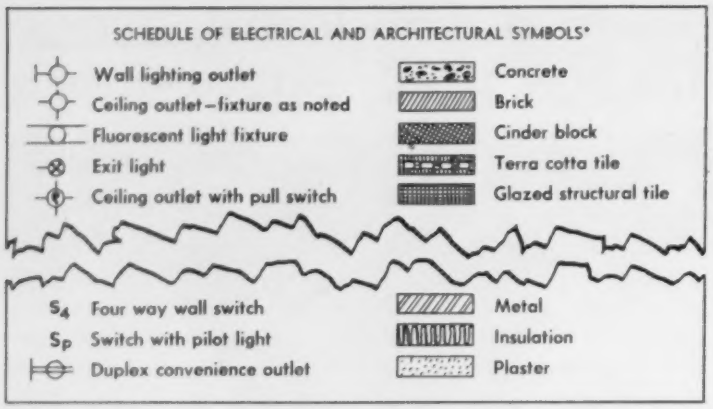
Only 12 calories per serving in D-Zerta! (Sugar-sweetened gelatins have up to 83 calories per serving!)

D-Zerta is carbohydrate free! *If* you recommend a low-calorie or sugar-free diet, your patients can *still* enjoy tempting desserts and refreshing salads.

Low-calorie, sugar-free D-Zerta costs about 4¢ a serving. Nutrition information and recipes with every package. D-Zerta can be found in the dietetic foods section of food stores.

Made by the makers of JELL-O desserts . . .
for those who must watch their sugar intake.

Jell-O and D-Zerta are registered trademarks of General Foods Corporation **A product of General Foods**



*The complete schedule of electrical and architectural symbols, together with information on sanitation standards and equipment sizes, is contained in the author's Food Service Equipment Data booklet. Copies of the booklet are available free of charge upon request from the Dietetics Specialist of the American Hospital Association.

in contact with chlorinated rubber in a moist condition, such as refrigerator door gaskets. The material is excellent for architectural applications, is a better conductor of heat than type #302, but is more difficult to fabricate because of brittleness.

GREATER COMPETITION

New equipment companies from time to time introduce new products with entirely new tools and dies. If the new product is good, then the older established companies use their experience and facilities to make even further improvements in their products and their customers profit by such competition.

This trend has been going on for a long time, retarded somewhat by depression and war, but noticeably stepped up in the past five years. These new products have offered far greater challenges than production managers like to endure.

With the knowledge of what equipment is needed and the kinds and sizes available, a study should be made to determine the most effective arrangement.

Scale templates (cutouts of each piece of equipment drawn to scale) are then made. The scale most often used is one-fourth inch equals one foot. This scale represents one-forty eighth of the full size. When the sizes and capacities of the equipment available are known, then a template of each equipment item can be made.

The templates are grouped into work units to provide the most direct flow of foodstuffs from the point of issue or receipt to the finished product. This arrangement of functional units determines the total area needed.

In remodeling, the problem is to arrange the equipment to best meet the needs in the space available.

Equipment consultants experienced in planning often use tracing paper over the scaled plan in making rapid sketches of alternate layouts of equipment. If one is not facile with the drafting pencil and scale rule, however, the "paper doll" system of using scale templates is easier. When an arrangement of the equipment appears to be final, then each template can be pasted, taped or pinned down in position on the floor plan.

When the best arrangement for the equipment has been determined and the working space allotted for, then a schematic drawing of the new or remodeled unit can be started.

SUMMARY

While there are standard pieces of food service equipment that can be described by name and catalogue number, only careful planning of the use of each piece of equipment will assure the dietitian and the architect that the selection of equipment is correct. By processing the menu through the equipment to determine the needs, studying the equipment items available and systematically arranging the equipment by the scale template method, the planning team is assured the equipment will meet the need. ■

Master Menus for April

THE AMERICAN Hospital Association's Master Menu is recognized by professionally qualified dietitians as a typical example of coördinated menu planning. The accepted basic menu pattern is followed in writing the general diet (items in bold face type). The normal diet forms the basis for the seven most commonly used modified hospital diets.

Summary of Dinner Meats

Dinner Meat	*Dates on menu*	*Total*
Beef	April 4-11-16-20-24-28	6
Veal	April 5-14-18-27	4
Lamb	April 12-23	2
Pork	April 2-10-19-25	4
Poultry	April 3-7-13-17-21-26	6
Fish	April 1-6-8-9-15-22-29	7
Variety Meats	April 30	1
		—
		30

In a limited amount of time the dietitian can make simple changes and adjustments in the AHA Master Menu to fit local conditions and individual hospital budgets. She then has more time to concentrate on the important details of food quality and quantity control and patient acceptance of the food.

Master Menu kits, containing wall cards, sample transfer slips and the *Master Menu Diet Manual* as well as complete directions for using the master menu, are available at $2 each. Single copies of the manual are priced at $1.50.

Other helpful information in menu planning can be found in the *Hospital Food Service Manual* ($6).

TODAY'S MOST MODERN COMMERCIAL GAS COOKING EQUIPMENT SPECIALLY DESIGNED FOR MODERATE SIZED KITCHENS

NEW

New features and styling, easy to keep clean and new-looking.

MODERN

Streamlined design throughout. Double-wall, double strength elevated shelf.

THRIFTY

Saves fuel. Saves operating time. Saves cleaning time.

DURABLE

Formed steel construction provides maximum strength. Welded joints are tight forever.

Available in Stainless Steel (as shown), Black Japan, or Lustre-Line gray finishes.

Magic Chef

CAFE LINE

commercial GAS cooking equipment

FOR INFORMATION WRITE Magic Chef, Inc., St. Louis 10, Missouri

IT SLASHES PREPARATION TIME . . . TURNS OUT TASTIER FOODS

For guide information in purchasing, see the *Master Menu Food Purchasing Guide* ($1.75) and *Manual of Specifications for Canned Fruits and Vegetables* ($2.50).

April 1

1. **Orange juice**
2. Orange juice
3. **Wheat and barley kernels or farina**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Vegetable soup**
8. **Crisp crackers**
9. **Baked flounder thermidor**
10. Poached flounder
11. **Parsley potatoes**
12. Parsley potatoes
13. **French green beans**
14. French green beans
15. **Hearts of lettuce salad**
16. **Russian dressing**
17. **Lemon custard ice cream**
18. Whole peeled apricots
19. Orange ice
20. Unsweetened peeled apricots
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Melba toast**
24. **Shrimp and celery salad—sliced tomatoes**
25. Cheese souffle—grape jelly
26. Low fat tuna with sliced tomatoes
27. Baked potato
28. **Sliced beets**
29. **Grapefruit and diced celery salad**
30. **Parisian dressing**
31. **Pineapple chunks**
32. Prune whip
33. Floating island
34. Fresh pineapple cubes
35. Mixed fruit juice
36. **Parker House rolls**

April 2

1. **Half grapefruit**
2. Blended citrus juice
3. **Oatmeal or crisp rice cereal**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Cream of corn soup**
8. **Croutons**
9. **Roast fresh ham**
10. Roast veal
11. **Whipped potatoes**
12. Whipped potatoes
13. **Swiss chard with lemon**
14. Sliced carrots
15. **Waldorf salad**
16. ———
17. **Gold cake—orange frosting**
18. Baked caramel custard
19. Cherry sponge
20. Orange slices
21. Orange juice

22. **Tomato juice**
23. ———
24. **Braised short ribs of beef**
25. Beef and noodle casserole
26. Broiled cubed steak
27. Noodles (omit on Soft Diet)
28. **Green peas**
29. **Cabbage and green pepper slaw**
30. **Sour cream dressing**
31. **Canned pears—chocolate nut cookies**
32. Canned pears
33. Cup custard
34. Unsweetened canned pears
35. Beef bouillon
36. **Hard rolls**

April 3

1. **Sliced orange**
2. Grapefruit juice
3. **Crisp oat cereal or hominy grits**
4. **Soft cooked egg**
5. Link sausage
6. **Sweet rolls**

7. **Apricot nectar**
8. ———
9. **Fried chicken**
10. Roast chicken
11. **Paprika potatoes**
12. Paprika potatoes
13. **Broccoli club style**
14. Mashed yellow squash
15. **Tossed raw vegetable salad bowl**
16. **Thousand Island dressing**
17. **Chocolate chip ice cream**
18. Chocolate chip ice cream
19. Lemon ice
20. Unsweetened canned loganberries
21. Beef bouillon

22. **Washington chowder**
23. **Crisp crackers**
24. **Creamed dried beef on Chinese noodles**
25. Toasted minced chicken sandwich—peach half
26. Cold sliced veal
27. Baked potato
28. **Asparagus tips**
29. **Grapefruit and avocado salad**
30. **French dressing**
31. **Praline chiffon cake**
32. Lime gelatin cubes
33. Lime gelatin cubes with custard sauce
34. Unsweetened canned prune plums
35. Apple juice
36. **Bread**

April 4

1. **Orange juice**
2. Orange juice
3. **Brown granular wheat cereal or puffed rice**
4. **Poached egg**
5. Canadian bacon
6. **Bran muffins**

7. **Consomme**
8. **Whole wheat wafers**
9. **Country fried steak**
10. Broiled steak
11. **Scalloped potatoes**
12. Riced potatoes
13. **Green beans**
14. Green beans
15. **Perfection salad**
16. **Lemon mayonnaise**
17. **Blueberry crumb pudding**
18. Bread pudding
19. Strawberry gelatin
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

22. **Cream of chicken soup**
23. **Saltines**
24. **Lamb stew with vegetables**
25. Broiled lamb pattie
26. Broiled lamb pattie
27. Parsley potatoes
28. **Spinach**
29. **Tomato and parsley salad**
30. **French dressing**
31. **Fresh fruit cup**
32. Banana and orange sections
33. Chocolate blanc mange
34. Fresh fruit cup
35. Pineapple juice
36. ———

April 5

1. **Half grapefruit**
2. Grapefruit juice
3. **Farina or bran flakes**
4. **Scrambled egg**
5. Crisp bacon
6. **Toast**

7. **Beef broth**
8. **Melba toast**
9. **Roast leg of veal—spiced prunes on cress**
10. Roast leg of veal
11. **Mashed potatoes**
12. Whipped potatoes
13. **Green peas**
14. Green peas
15. **Mixed green salad**
16. **French dressing**
17. **Peppermint stick candy tapioca**
18. Vanilla tapioca
19. Jellied apricot nectar
20. Unsweetened apple sauce
21. Lemonade

22. **Vegetable soup**
23. **Saltines**
24. **Ham and noodle loaf, mushroom sauce**
25. Sliced chicken
26. Sliced chicken
27. Baked noodles in broth
28. **Julienne beets**
29. **Sliced orange and watercress salad**
30. **Parisian French dressing**
31. **Lime ice—gumdrop bars**
32. Peach half with lime ice
33. Lime ice
34. Unsweetened peaches
35. Blended citrus juice
36. **French bread**

April 6

1. **Sliced banana**
2. Orange juice
3. **Corn flakes or rolled wheat**
4. **Soft cooked egg**
5. Crisp bacon
6. **Cinnamon toast**

7. **Alphabet soup**
8. **Saltines**
9. **Broiled halibut with pepper relish**
10. Broiled halibut
11. **New potatoes in jackets**
12. New potatoes
13. **Julienne green beans**
14. Julienne green beans
15. **Celery hearts, radishes and scallions**
16. ———
17. **Cherry cobbler**
18. Jelly roll
19. Raspberry rennet custard
20. Unsweetened pineapple slices
21. Blended citrus juice

22. **Cream of asparagus soup**
23. **Crisp crackers**
24. **Seafood Newburg on rice**
25. Broiled liver
26. Broiled liver
27. Baked potato
28. **Patty pan squash**
29. **Sliced tomatoes on cress**
30. **French dressing**
31. **Jelly roll**
32. Canned peeled apricots
33. Soft custard
34. Unsweetened apricots
35. Grapefruit juice
36. **Bread**

April 7

1. **Grapefruit juice**
2. Grapefruit juice
3. **Hominy grits or shredded wheat**
4. **Poached egg**
5. Link sausages
6. **Toast**

7. **Julienne vegetable soup**
8. **Crisp crackers**
9. **Turkey pie with pastry cover**
10. Roast turkey
11. **Boiled potatoes**
12. Boiled potatoes
13. **Seven-minute cabbage**
14. Sliced carrots
15. **Jellied beet and horseradish salad**
16. **Mayonnaise**
17. **Dutch apple pie**
18. Cream cheese, guava jelly, toasted crackers
19. Strawberry gelatin
20. Grapefruit and orange cup
21. Limeade

22. **Orange juice with raspberry ice**
23. ———
24. **Veal loaf, pimiento cream sauce**
25. Veal souffle
26. Broiled veal pattie
27. Latticed potatoes
28. **Spinach with lemon**
29. **French pineapple fan salad**
30. **French dressing**
31. **Prune whip cake with prune whip frosting**
32. Prune whip
33. Baked custard
34. Unsweetened Royal Anne cherries
35. Consomme
36. **Hard rolls**

April 8

1. **Orange juice**
2. Orange juice
3. **Crisp corn cereal or oatmeal**
4. **Baked egg** (omit on Normal Diet).
5. Grilled ham
6. **French toast—syrup**

7. **Tomato bouillon**
8. **Saltines**
9. **Baked bluefish**
10. Broiled bluefish
11. **Parsley potatoes**
12. Parsley potatoes
13. **Green peas**
14. Green peas
15. **Apricot, cream cheese and watercress salad**
16. **French dressing**
17. **Butter pecan ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Honeydew melon
21. Grapefruit juice

22. **Green split pea soup**
23. **Crisp crackers**
24. **Cheese rice croquette—mushroom sauce and currant jelly**
25. Baked rice with cheese—currant jelly
26. Low fat tuna
27. Baked potato
28. **Fresh asparagus**
29. **Apple, grapefruit and date salad**
30. **French dressing**
31. **Ambrosia pie**
32. Canned pear halves
33. Orange gelatin cubes
34. Unsweetened pear halves
35. Pineapple juice
36. **Poppy seed rolls**

April 9

1. **Tomato juice**
2. Tomato juice
3. **Rolled wheat or puffed rice**
4. **Soft cooked egg**
5. Crisp bacon
6. **Sweet rolls**

7. **Consomme**
8. **Paprika crackers**
9. **Salmon loaf with egg sauce**
10. Poached haddock
11. **Scalloped potatoes**
12. Cubed potatoes
13. **Diced straightneck squash**
14. Diced straightneck squash
15. **Hearts of escarole**
16. **Thousand Island dressing**
17. **Pineapple upside-down cake—whipped cream**
18. Fruited gelatin, whipped cream
19. Strawberry gelatin
20. Fresh pineapple
21. Blended citrus juice

22. **Cream of spinach soup**
23. **Croutons**
24. **Beef and biscuit roll, brown gravy**
25. Minced veal
26. Cold sliced veal
27. Potato balls
28. **Wax beans**
29. **Head lettuce salad**
30. **Chiffonade dressing**
31. **Baked rhubarb sauce—sugar cookies**
32. Home style peaches
33. Soft custard
34. Unsweetened red raspberries
35. Grapefruit juice
36. **Bread**

April 10

1. **Grapefruit half**
2. Blended citrus juice
3. **Corn flakes or Scotch bran brose**
4. **Scrambled egg**
5. Canadian bacon
6. **Raisin bread toast**

7. **Beef bouillon**
8. **Saltines**
9. **Baked Virginia ham with orange and raisin sauce**
10. Hot sliced turkey
11. **Mashed potatoes**
12. Steamed rice
13. **Frozen green Lima beans**
14. Asparagus tips
15. **Ginger ale fruit gelatin salad**
16. **Cream mayonnaise**
17. **Fresh strawberry sundae**
18. Vanilla ice cream
19. Orange ice
20. Fresh strawberries
21. Grapefruit juice

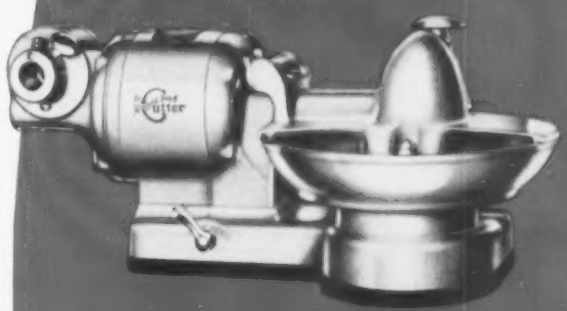
22. **Corn chowder**
23. **Crisp crackers**
24. **Chicken salad with cinnamon apple on cress**
25. Broiled lamb pattie—carrots

IT SLASHES PREPARATION TIME . . . TURNS OUT TASTIER FOODS
. . . GETS MORE OUT OF INGREDIENTS . . . CONVERTS OVER-RUNS
AND LEFTOVERS INTO USABLE, TOP-QUALITY PRODUCTS

CUT COSTS by the BOWLFUL

. . . every few minutes!

Prepares– Croquettes and Patties • Leaf and Root Vegetables Canned, Fresh, Dried or Candied Fruits Nuts, Dates, Figs • Fresh or Dried Bread or Cracker Crumbs • Soup Stocks • Canapé Spreads Pastry Topping • Filling, Flavoring



Here's finer, more all-purpose food production in machine-minutes instead of hand-hours! Now you can uniformly cut, and mix—with a fineness of cut directly controlled by the period of operation—all the preparation shown and many more. Your new Hobart Food Cutter will pay for itself so quickly in kitchen, salad pantry and bake shop, that you'll wonder how you ever operated without it.

High speed Hobart-designed cutlery steel knives deliver a unique, clean draw-cut without pressure or metal-to-metal contact that is even effective with soft fresh fruits. The revolving bowl thoroughly mixes ingredients as it cuts, when desired. For instance, all ingredients for dressings can be prepared in one batch. Many vegetables, such as carrots or cabbage, can be cut without peeling or whole.

No other kitchen machine offers such universal use —such a money-saving range of production. And it's a Hobart product: safe—clean in design and performance—built and guaranteed for long, dependable service. It will pay you to make arrangements for a demonstration of this "*work-horse* of the kitchen."
The Hobart Manufacturing Company, Troy, Ohio.

Add the Hobart Food Chopper, too! Reduce waste in the form of meat and food scraps turned into tempting, appetizing croquettes, meat patties, sausage, etc. No crushing or mashing of meat—natural color and flavor fully retained!

It's Hobart for all your food machines

MULTI-USE for your FOOD CUTTER!

Add the Hobart 9" Vegetable and Fruit Slicer—coarse and fine shredder plates—Julienne plate, grater plate—French fry plate—adjustable width slicer plate. Hopper front (illustrated) can be replaced with tubular front when right-angle cutting is desired, as in cutting celery. Try it—and watch production jump!

Trademark of Quality Hobart for over 55 years

Hobart
Food Machines

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

26. Broiled lamb pattie—carrots
27. Baked potato
28. ———
29. **Celery hearts**
30. ———
31. **Crusted pear, chilled custard sauce**
32. Canned fruit cup
33. Raspberry gelatin, custard sauce
34. Unsweetened fruit cup
35. Mixed fruit juice
36. ———

April 11

1. **Banana**
2. Apricot nectar with lemon juice
3. **Granular wheat cereal or crisp rice cereal**
4. **Poached egg**
5. Crisp bacon
6. **Toast**

7. **Consomme**
8. **Celery crackers**
9. **Roast top sirloin of beef**
10. Roast top sirloin of beef
11. **Oven browned potatoes**
12. Steamed potatoes
13. **Sliced beets**
14. Sliced beets
15. **Chef's salad bowl**
16. **Thousand Island dressing**
17. **Bread pudding, lemon sauce**
18. Bread pudding, lemon sauce
19. Mocha sponge
20. Unsweetened apricots
21. Tomato juice

22. **Fresh vegetable soup**
23. **Saltines**
24. **Smoked beef tongue—corn relish**
25. Creamed sweetbreads on toast
26. Hot sliced tongue
27. Baked noodles
28. **Green peas**
29. **Sliced orange salad**
30. **French dressing**
31. **Coconut layer cake**
32. Jellied canned pear
33. Baked custard
34. Unsweetened canned peaches
35. Pineapple juice
36. **Crusty hard roll**

April 12

1. **Orange juice**
2. Orange juice
3. **Puffed wheat or oatmeal**
4. **Soft cooked egg**
5. Link sausages
6. **Toast**

7. **Chicken gumbo**
8. **Toasted bread sticks**
9. **Roast lamb with gravy**
10. Roast lamb
11. **Mashed potatoes**
12. Riced potatoes
13. **Zucchini squash slices**
14. Carrot rings
15. **Molded bing cherry salad**
16. **Cream mayonnaise**
17. **Rice apple pudding with light cream**
18. Rice Bavarian
19. Raspberry gelatin
20. Unsweetened plums
21. Limeade

22. **Cream of asparagus soup**
23. **Saltines**
24. **Broiled Canadian bacon—banana scallops**
25. Scrambled eggs—bacon curls
26. Cold roast beef
27. Baked potato
28. **Whole green beans**
29. **Vegetable relish plate**
30. ———
31. **Fresh pineapple**
32. Royal Anne cherries
33. Floating island
34. Fresh pineapple
35. Tomato juice
36. **Blueberry muffins**

April 13

1. **Honeydew melon**
2. Grapefruit juice
3. **Farina or wheat and barley kernels**
4. **Poached egg**
5. Crisp bacon
6. **Toast**

7. **Beef bouillon**
8. **Crisp crackers**
9. **Chicken pie**
10. Roast chicken
11. **Parsley potatoes**
12. Parsley potatoes
13. **Spanish corn**
14. Garden spinach
15. **Stuffed prune salad**
16. **Paprika French dressing**
17. **Chocolate ice cream**
18. Chocolate ice cream
19. Lemon ice
20. Unsweetened Royal Anne cherries
21. Blended citrus juice

22. **Cream of celery soup**
23. **Toasted crackers**
24. **Hamburger with chopped olives on toasted bun—potato sticks**
25. Beef pattie—asparagus tips
26. Beef pattie—asparagus tips
27. Baked sweet potato
28. ———
29. **Sliced tomato salad**
30. **French dressing**
31. **Banana cream pie in graham cracker crust**
32. Sliced banana in orange juice
33. Vanilla cream pudding
34. Fresh orange cup
35. Frozen grape juice
36. ———

April 14

1. **Grapefruit half**
2. Grapefruit juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Grilled ham
6. **Toast**

7. **Consomme**
8. **Whole wheat crackers**
9. **Breaded veal cutlet**
10. Broiled veal chop
11. **Whipped potatoes**
12. Steamed potatoes
13. **New beets and greens**
14. New beets
15. **Apricot and date salad**
16. **Cream mayonnaise**
17. **Pineapple graham cracker pudding**
18. Lemon meringue pudding
19. Pineapple whip
20. Seedless grapes
21. Grapefruit juice

22. **Chicken noodle soup**
23. **Crisp crackers**
24. **Creole liver**
25. Broiled liver
26. Broiled liver
27. Parsley potato balls
28. **Quartered carrots**
29. **Head lettuce salad**
30. **Chiffonade dressing**
31. **Fresh fruit cup—hermits**
32. Canned pears
33. Baked custard
34. Fresh fruit cup
35. Limeade
36. **Bread**

April 15

1. **Orange halves**
2. Orange juice
3. **Rolled wheat or crisp rice cereal**
4. **Soft cooked egg**
5. Crisp bacon
6. **Toast**

7. **Vegetable soup**
8. **Saltines**
9. **Baked whitefish—lemon garnish**
10. Broiled whitefish
11. **Paprika potatoes**
12. Riced potatoes
13. **Stewed tomatoes**
14. Asparagus
15. **Cabbage slaw**
16. **Slaw dressing**
17. **Chocolate eclair**
18. Chocolate blanc mange
19. Lemon gelatin cubes
20. Grapefruit sections with sliced banana
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Melba toast**
24. **Salmon loaf, parsley cream sauce**
25. Creamed salmon
26. Cold salmon on lettuce
27. Stuffed baked potato
28. **Green peas**
29. **Celery curls**
30. ———
31. **Kadota figs**
32. Canned peeled apricots
33. Chocolate blanc mange
34. Unsweetened canned Kadota figs.
35. Grapefruit juice
36. **Butterhorn rolls**

April 16

1. **Grapefruit juice**
2. Grapefruit juice
3. **Corn flakes or oatmeal**
4. **Poached egg** (omit on Normal Diet)
5. Crisp bacon
6. **Bacon—cinnamon rolls**

7. **Beef broth**
8. **Crisp crackers**
9. **Beef loaf, brown mushroom gravy**
10. Broiled steak
11. **Scalloped potatoes**
12. Baked potato
13. **Wax beans**
14. Wax beans
15. **Two-decker tomato cottage cheese salad**
16. **Mayonnaise**
17. **Boston cream pie**
18. Boston cream pie
19. Cherry sponge
20. Unsweetened apricots
21. Orange juice

22. **Minestrone soup**
23. **Saltines**
24. **Scrambled eggs with pork link sausage**
25. Scrambled eggs
26. Grilled chicken livers—broiled tomato
27. Noodles
28. **Spinach with lemon**
29. **Assorted relish plate**
30. ———
31. **Frosted fruit cup**
32. Jellied canned fruit
33. Strawberry gelatin
34. Sliced oranges
35. Apple juice
36. **Honey graham muffins**

April 17

1. **Orange juice**
2. Orange juice
3. **Farina or raisin bran flakes**
4. **Soft cooked egg**
5. Grilled sausage cake
6. **Toast**

7. **Consomme**
8. **Whole wheat wafers**
9. **Roast turkey, dressing and gravy**
10. Roast turkey
11. **New potatoes**
12. New potatoes
13. **Broccoli**
14. Diced beets
15. **Jellied cranberry—orange salad**
16. **Mayonnaise dressing**
17. **Coffee ice cream**
18. Coffee ice cream
19. Lime ice
20. Grapefruit sections
21. Grapefruit juice

22. **Tomato bouillon**
23. **Saltines**
24. **Welsh rarebit on toast—bacon curls**
25. Broiled lamb chop
26. Broiled lamb chop
27. Baked potato
28. **Asparagus tips**
29. **Green and red cabbage salad**
30. **Cream dressing**
31. **Home style peaches**
32. Home style peaches
33. Soft custard
34. Unsweetened peaches
35. Pineapple juice
36. **Bread**

April 18

1. **Tomato juice**
2. Tomato juice
3. **Shredded wheat or hominy grits**
4. **Scrambled egg**
5. Grilled ham
6. **Coffee ring**

7. **Beef bouillon**
8. **Crisp crackers**
9. **Baked veal roll**
10. Roast leg of veal
11. **Pittsburgh potatoes**
12. Baked potatoes
13. **Green peas**
14. Green peas
15. **Stuffed celery with sliced ripe olive garnish**
16. ———
17. **Gingerbread with sliced bananas and whipped cream**
18. Vanilla cream pudding
19. Cherry and lemon gelatin cubes
20. Sliced orange
21. Orange juice

22. **Cream of chicken soup**
23. **Croutons**
24. **Chopped beef and mushroom saute on toast**
25. Broiled beef pattie
26. Broiled beef pattie
27. Parslied potato balls
28. **Sliced carrots**
29. **Raw spinach, lettuce and radish salad bowl**
30. **Vinegar-oil dressing**
31. **Applesauce and oatmeal cookies**
32. Applesauce
33. Vanilla cream pudding
34. Fresh pineapple
35. Apricot nectar
36. **Bread**

April 19

1. **Grapefruit half**
2. Grapefruit juice
3. **Oatmeal or puffed rice**
4. **Poached egg**
5. Crisp bacon
6. **Toast**

7. **Beef broth**
8. **Saltines**
9. **Baked ham—raisin sauce**
10. Roast lamb
11. **Candied sweet potatoes**
12. Steamed potatoes
13. **Whole green beans**
14. Whole green beans
15. **Apple, celery and pineapple salad**
16. **Lemon mayonnaise**
17. **Chocolate fudge pudding, whipped cream**
18. Chocolate pudding, whipped cream
19. Pineapple whip
20. Unsweetened canned plums
21. Blended citrus juice

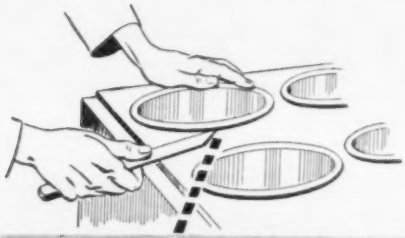
22. **Onion soup**
23. **Rye cheese croutons**
24. **Baked liver—stuffed baked potato**
25. Broiled liver—new beets
26. Broiled liver—new beets
27. Baked potato
28. ———
29. **Tossed salad with tomato quarters**
30. **French dressing**
31. **Baked rhubarb sauce with gumdrop bars**
32. Canned fruit cup
33. Chocolate pudding
34. Unsweetened fruit cocktail
35. Mixed fruit juice
36. **Cornbread**

April 20

1. **Sliced orange**
2. Prune juice with lemon
3. **Corn flakes or granular wheat cereal**
4. **Soft cooked egg**
5. Link sausage
6. **Cinnamon breakfast muffins**

7. **Consomme**
8. **Crisp crackers**
9. **Pot roast of beef**
10. Pot roast of beef
11. **Paprika potatoes**
12. Paprika potatoes
13. **Stewed tomatoes and okra**
14. Julienne carrots
15. **Head lettuce salad**
16. **Chiffonade dressing**
17. **Raspberry sherbet**
18. Raspberry sherbet
19. Raspberry ice
20. Unsweetened canned Bing cherries
21. Grapefruit juice

22. **Vegetable soup**
23. **Toasted crackers**
24. **Spanish rice with crisp bacon**
25. Rice and cheese casserole
26. Roast veal
27. Fluffy rice
28. **Fresh spinach**
29. **Orange and date salad**
30. **Lemon mayonnaise**



No Knife-Scraping Needed

. . . BECAUSE THERE ARE NO CREVICES

ORDINARY CONSTRUCTION
showing food conveyor top with crevices around each well.

Seamless, sanitary top eliminates dirt-collecting crevices on all Blickman-Built Food Conveyors

BLICKMAN SANITARY TOP
showing smooth, continuous surfaces where wells meet top deck. Cleaning is simple and quick. There are no crevices where dirt can lodge.

• In ordinary food conveyor construction, wells are separate units, forming crevices where edges are joined to top deck. These crevices form natural traps for food and dirt particles. Usually, adhesions can be loosened only by scraping with a knife or other sharp instrument. Even then, deposits can't be completely removed. It is impossible to achieve real cleanliness. Extra time and labor are required every time the conveyor is cleaned.

Blickman's new seamless top construction, however, permits thorough sanitation. Round and rectangular wells are *actually part of the top deck.* Where edges of the wells meet the top, they form *smooth, continuous, crevice-free surfaces.* There are no recesses where dirt can lodge. Cleaning is quick and easy. Just wiping with a damp cloth keeps the highly-polished stainless steel surfaces bright, clean-looking, sanitary!

Blickman-Built food conveyors alone offer the seamless, sanitary top as standard construction. Investigate this—and other essential features, before you buy your next food conveyor.

SEND FOR *New* VALUABLE BOOK
Describing complete line of Blickman-Built food conveyors, including the widely-acclaimed selective-menu models. Contains detailed specifications.

the *New* Selective Menu Food Conveyor

One conveyor now gives you a great variety of inset arrangements for your selective menus. Interchangeable square and rectangular pans can be placed in the rectangular wells in different combinations. Round wells are used for soup or other liquids; two heated drawers for special diets. There are many other interesting features—write for complete information.

S. Blickman, Inc., 3803 Gregory Avenue, Weehawken, N. J.

Blickman-Built
FOOD SERVICE EQUIPMENT
EST 1889

COFFEE URNS · STEAM TABLES · FOOD CONVEYORS · SINKS · WORK TABLES

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 28-30.

31. **Devil's food cake with coconut icing**
32. Canned Royal Anne cherries
33. Baked custard
34. Fresh raspberries
35. Tomato juice
36. **Cloverleaf rolls**

April 21

1. **Grapefruit juice**
2. Grapefruit juice
3. **Farina or wheat flakes**
4. **Poached egg**
5. Crisp bacon
6. **Toast**

7. **Beef bouillon**
8. **Whole wheat wafers**
9. **Chicken fricassee**
10. Roast chicken
11. **Noodles**
12. Noodles
13. **Green peas**
14. Green peas
15. **Lettuce, endive and watercress salad**
16. **Lorenzo dressing**
17. **Fresh pineapple—brownies**
18. Spanish cream
19. Grape sponge
20. Fresh pineapple
21. Orange juice

22. **Corn chowder**
23. **Croutons**
24. **Baked individual ham roll with fruit stuffing**
25. Bacon curls
26. Broiled lamb chop
27. Baked macaroni
28. **Asparagus**
29. **Fresh fruit salad**
30. **Fruit salad—dressing**
31. **Spanish cream**
32. Steamed rice, apricot sauce
33. Spanish cream
34. Unsweetened apricots
35. Grapefruit juice
36. **Orange biscuits**

April 22

1. **Orange juice**
2. Orange juice
3. **Crisp corn cereal or rolled wheat**
4. **Scrambled egg**
5. Link sausage
6. **Toast**

7. **Mushroom bouillon**
8. **Crisp crackers**
9. **Broiled mackerel—lemon slice**
10. Broiled mackerel—lemon slice
11. **Mashed potatoes**
12. Whipped potatoes
13. **Whole kernel corn**
14. Chopped spinach
15. **Head lettuce salad**
16. **Cucumber mayonnaise**
17. **Latticed cherry pie**
18. Baked custard
19. Raspberry gelatin
20. Unsweetened red raspberries
21. Grapefruit juice

22. **Cream of asparagus soup**
23. **Toasted crackers**
24. **Baked omelet**
25. Fluffy omelet
26. Broiled chicken livers
27. Baked potato
28. **Julienne green beans**
29. **Tomato and watercress salad**
30. **Thousand Island dressing**
31. **Canned pears—hermits**
32. Canned pears
33. Baked custard
34. Unsweetened canned pears
35. Mixed fruit juice
36. **Bread**

April 23

1. **Banana**
2. Citrus juice
3. **Granular wheat cereal or crisp rice cereal**
4. **Soft cooked egg**
5. Grilled Canadian bacon
6. **Raisin bread toast**

7. **Beef broth**
8. **Saltines**
9. **Roast leg of lamb—mint jelly**
10. Roast leg of lamb
11. **Fluffy rice**
12. Fluffy rice
13. **Quartered carrots**
14. Quartered carrots
15. **Grapefruit and avocado salad**
16. **Fruit French dressing**
17. **Boysenberry cobbler**
18. Pineapple whip—custard sauce
19. Pineapple whip
20. Unsweetened boysenberries
21. Orange juice

22. **French onion soup**
23. **Rye croutons**
24. **Swedish meat balls**
25. Broiled chopped steak
26. Broiled chopped steak
27. Paprika cubed potatoes
28. **Green peas**
29. **Crisp green salad**
30. **French dressing with crumbled cheese**
31. **Jelly roll**
32. Jelly roll
33. Chocolate pudding
34. Unsweetened prune plums
35. Pineapple juice
36. **Bread**

April 24

1. **Orange halves**
2. Orange juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Crisp bacon
6. **Sweet rolls**

7. **Consomme**
8. **Crisp crackers**
9. **Roast prime rib of beef**
10. Roast beef
11. **Mashed potatoes**
12. Mashed potatoes
13. **Wax beans**
14. Wax beans
15. **Cabbage, spinach and apple salad**
16. ———
17. **Peppermint stick ice cream**
18. Peppermint stick ice cream
19. Lime ice
20. Unsweetened bing cherries
21. Grapefruit juice

22. **Cream of tomato soup**
23. **Toasted crackers**
24. **Chicken and noodles au gratin**
25. Creamed chicken
26. Cold sliced chicken
27. Baked potato
28. **Diced squash**
29. **Asparagus and pimiento salad**
30. **Vinaigrette dressing**
31. **Fresh fruit cup**
32. Orange and banana cup
33. Vanilla rennet-custard
34. Fresh fruit cup with blueberries
35. Blended juice
36. **Rye bread**

April 25

1. **Grapefruit half**
2. Grapefruit juice
3. **Farina or crisp rice cereal**
4. **Poached egg**
5. Grilled chicken livers
6. **Toast**

7. **Beef bouillon**
8. **Saltines**
9. **Breaded pork chops**
10. Broiled veal pattie
11. **Golden crusted potatoes**
12. Steamed potatoes
13. **Brussels sprouts**
14. Sliced beets
15. **Julienne beet and escarole salad**
16. **Horse radish French dressing**
17. **Apple crisp**
18. Baked custard, apricot sauce
19. Whipped lemon gelatin
20. Unsweetened canned pears
21. Blended citrus juice

22. **Vegetable soup**
23. **Crisp crackers**
24. **Beef stew with vegetables**
25. Broiled cubed steak
26. Broiled cubed steak
27. Steamed rice
28. **Spinach with lemon**
29. **Orange and banana salad**
30. **French dressing**
31. **Angel food cake**
32. Angel food cake
33. Baked custard
34. Unsweetened peaches
35. Grape ade
36. **Hard rolls**

April 26

1. **Tomato juice**
2. Tomato juice
3. **Shredded wheat or hominy grits**
4. **Soft cooked egg**
5. Link sausage
6. **Raisin bread toast**

7. **Consomme**
8. **Whole wheat wafers**
9. **Roast turkey roll with dressing and gravy**
10. Roast turkey
11. **Potato puff**
12. Potato balls
13. **Cauliflower**
14. Asparagus
15. **Sliced head lettuce salad**
16. **Thousand Island dressing**
17. **Orange date-nut cake with whipped cream**
18. Cherry sponge
19. Cherry sponge
20. Orange sections
21. Limeade

22. **Corn chowder**
23. **Saltines**
24. **Frankfurters stuffed with cheese and bacon wrap—creamed potatoes**
25. Grilled bacon
26. Broiled lamb pattie
27. Stuffed baked potato
28. **Sliced carrots**
29. **Tossed salad**
30. **Celery seed French dressing**
31. **Grapefruit sections and fresh strawberries**
32. Fresh applesauce
33. Soft custard
34. Fresh strawberries
35. Orange juice
36. **Finger rolls**

April 27

1. **Sliced banana**
2. Prune juice with lemon
3. **Rolled wheat or crisp corn cereal**
4. **Scrambled egg**
5. Crisp bacon
6. **Honey buns**

7. **Grapefruit juice**
8. ———
9. **Roast leg of veal with dressing**
10. Roast leg of veal
11. **Potatoes au gratin**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Shredded carrot and raisin salad**
16. **Cream dressing**
17. **Chocolate sundae**
18. Cranberry ice
19. Cranberry ice
20. Grapefruit sections
21. Consomme

22. **Tomato soup**
23. **Crisp crackers**
24. **Chicken chop suey Chinese noodles—spiced peach**
25. Creamed sweetbreads—beets
26. Broiled sweetbreads—beets
27. Baked sweet potato
28. ———
29. **Head lettuce salad**
30. **Russian dressing**
31. **Royal Anne cherries—pecan puffs**
32. Royal Anne cherries
33. Vanilla ice cream
34. Unsweetened Royal Anne cherries
35. Blended citrus juice
36. **Potato rusks**

April 28

1. **Orange juice**
2. Orange juice
3. **Puffed rice or oatmeal**
4. **Soft cooked egg**
5. Grilled Canadian bacon
6. **Toast**

7. **Beef bouillon**
8. **Crisp crackers**
9. **Swiss steak**
10. Broiled steak
11. Paprika potatoes
12. Paprika potatoes
13. **Green beans**
14. Green beans
15. **Grapefruit, stuffed prune salad, cherry garnish**
16. **Maraschino French dressing**
17. **Lemon sponge**
18. Lemon sponge
19. Lemon snow pudding
20. Unsweetened canned apricots
21. Blended citrus juice

22. **Cream of mushroom soup**
23. **Saltines**
24. **Brown fricassee of veal**
25. Minced veal—diced squash
26. Diced veal—broiled tomato—mixed green salad
27. Parsley potato balls
28. ———
29. **Sliced tomato salad**
30. **French dressing**
31. **Fruit gelatin with whipped cream**
32. Canned fruit cocktail
33. Raspberry gelatin with custard sauce
34. Unsweetened apple sauce
35. Pineapple juice
36. **Cinnamon biscuits**

April 29

1. **Grapefruit half**
2. Grapefruit juice
3. **Farina or bran flakes**
4. **Poached egg**
5. Crisp bacon
6. **Whole wheat raisin toast**

7. **Essence of celery broth**
8. **Saltines**
9. **Golden crusted ocean perch**
10. Broiled ocean perch
11. **Mashed potatoes**
12. Mashed potatoes
13. **Stewed tomatoes**
14. Sliced carrots
15. **Cole slaw**
16. ———
17. **Deep dish apple pie**
18. Jelly-crested baked custard
19. Lime and lemon gelatin cubes
20. Fresh pineapple
21. Citrus juice

22. **Cream of asparagus soup**
23. **Croutons**
24. **Scalloped tuna fish with noodles**
25. Creamed tuna
26. Low fat tuna on lettuce
27. Baked potato
28. **Green peas**
29. **Sliced orange and watercress salad**
30. **French dressing**
31. **Burnt sugar layer cake**
32. Canned pears
33. Baked custard
34. Unsweetened canned pear
35. Frozen grape juice
36. **Bread**

April 30

1. **Orange juice**
2. Orange juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Crisp bacon
6. **Toast**

7. **Beef broth**
8. **Celery crackers**
9. **Creole liver**
10. Roast lamb
11. **Creamed new potatoes**
12. Parsley potatoes
13. **Spinach with lemon**
14. Spinach with lemon
15. **Banana salad, cherry garnish**
16. **Cream mayonnaise**
17. **Cottage pudding, hot fudge sauce**
18. Cottage pudding, vanilla sauce
19. Maple mold
20. Orange slices
21. Blended citrus juice

22. **Cream of tomato soup**
23. **Saltines**
24. **Assorted cold cuts—potato salad**
25. Broiled beef pattie—beets
26. Broiled beef pattie—beets
27. Mashed potatoes
28. ———
29. **Vegetable relishes**
30. ———
31. **Fruit compote—molasses cookies**
32. Canned peaches
33. Whipped lime gelatin
34. Unsweetened peaches
35. Pineapple juice
36. **Pumpernickel bread**

AMAZING COFFEE DISCOVERY

Now Packed for Quantity Brewing!

A Product of General Foods

Not a powder! Not a grind! But millions of tiny "FLAVOR BUDS" of real coffee...ready to burst instantly into that famous Good-to-the-Last-Drop flavor!

Only this entirely new *kind* of coffee gives you all these advantages:

- 10% greater yield per pound-equivalent pack!
- Cuts brewing time and labor costs 75%!
- Any worker, trained or not, can brew it perfectly!
- Uniform cup quality—ends "in-and-out" batches!
- No more "staling" problems—saves storage space!
- No more coffee grounds—makes cleaning a cinch!
- No more urn bags, upper bowls, rings or filters!
- Can be brewed in small batches anywhere, anytime!

See your Maxwell House Man today, or write: Maxwell House Div., H&R Dept., Hoboken, N. J.

HOSPITAL PLANNING REQUIREMENTS

...TO GUIDE THE RISING GENERATION OF ARCHITECTS

BY GUY ALDIS A.R.I.B.A., A.A. Dipl.

Architect to the East Anglian Regional Hospital Board

HOSPITAL PLANNING REQUIREMENTS. Guy Aldis, A.R.I.B.A., A.A. Dipl. London, Sir Isaac Pitman and Sons, Ltd., 1954. 257 p. $11.90.

The author, architect to the East Anglican Regional Hospital Board, has written this book primarily for the guidance of architects. It originates from a study of the deficiencies found in typical hospitals as they exist in England.

The information and recommendations have been gleaned from many years of personal research and interviews, both in England and North America. Although generously illustrated, the book has no plans of actual hospitals as such. Written in outline form with a minimum of text, it includes over 400 diagrams which tell the story. Besides the inpatient accommodations and services, the author deals extensively with outpatient facilities.

In one of the several forewords, the late L. A. Pearson states: ". . . it should be pointed out that in this country, we have our own problems which result from our habits, climate and financial limitations; and for this reason we must not rely too much on work done in other countries."

To the reader on our own continent, this observation may be applied in reverse. Here, the open 20-bed ward dating from the days of Florence Nightingale has all but disappeared. There, the subdivision of these wards into smaller units and the turning of the patients beds parallel to the windows is a relatively new concept. This is not to detract from the significance of the work; rather, the importance is magnified by recognition of these circumstances of the setting.

In our country, hospital design has advanced partly because of the many opportunities in the last decade to analyze the problem and to create new designs. In England, where very few new hospitals have been built in the past 20 years, there is much need to revise and make better use of existing facilities. Therein lies the motivation in part for this book. The primary purpose, however, is to provide a sourcebook of fundamentals to guide the rising generation of architects who will be designing new hospitals.

The author emphasizes the responsibility of the architect to be comprehensive as well as incisive in soliciting the needs of the patient, the physician, the nurse and others who assist in care of the sick. In fulfillment of this admonition, there is need for interpolation in applying the text and diagrams to the American scene. Nevertheless, the mature professional will find this book a worthy addition to the few definitive works in hospital planning.—CLIFFORD WOLFE.

Building guide

A GUIDE TO HOSPITAL BUILDING IN ONTARIO. Toronto, University of Toronto Press, 1954. 307 p. $10.

This book was prepared by the Committee on Designing, Constructing and Equipping of Public Hospitals in Ontario and printed by authority of the Hon. Mackinnon Phillips, M.D., C.M., minister of health for Ontario. The Executive Committee, appointed to prepare this guide, collaborated with a larger General Committee representing various technical professions related to hospital planning.

Although this book is specifically intended as a guide to hospital planning in Ontario, it deserves much wider reference and recognition. It is fundamental, comprehensive and definitive, yet clearly and simply written. The work must be acknowledged as a major contribution to the hospital planning literature.

In the foreword by the minister, it is stated that there should be some uniformity of hospital construction throughout the province. It is emphasized, however, that the suggestions contained in the book are not to be considered as government regulations or as a building code but rather as a guide to hospital planning. Elsewhere, the authors caution against standardization of plans or the adoption of prototypes. For this reason, the illustrations consist of unit plans that are essentially diagrammatic.

Similarly, tabular data are provided only for general guidance. The program requirements for each hospital must be developed individually in response to factors affecting the given situation. In the various chapters, general considerations are outlined with respect to the many aspects of the hospital planning problem.

There is some similarity of content between this volume and the parallel work, *Design and Construction of General Hospitals*, by the U.S. Public Health Service (reviewed on p. 130 of HOSPITALS, April 1954). The outline style is one point of departure. The unit plans also differ in most instances, although they resemble those developed earlier by the U.S. Public Health Service, Division of Hospital Facilities.

In addition to the chapters covering planning of component services of the hospital, the appendixes provide guidance in convenient

Here's how

HIGH HUMIDITY THERAPY

has progressed

first came	LIVE STEAM
then came	SPINNING HUMIDIFIERS
then	NEBULIZED WATER VAPOR
then	HIGH HUMIDITY INSUFFLATORS
then	HUMIDITY TENTS

AND NOW . . .

AN ENTIRE HOSPITAL ROOM WITH

Actual photograph of Humidity Room with Melco "Natural Fog" Generator in operation.

COOL, COMFORTABLE, MOIST "NATURAL FOG"

What is "Natural Fog"?

When nature combines two streams of air, one chilled and the other heated, the result is "Natural Fog." Now, man has been able to duplicate nature, and even to improve upon it, in that the heated stream of air can be supersaturated, and temperature prescribed.

You can now for the first time completely fill an entire hospital room with dense supersaturated fine fog without precipitation. You can now maintain in that room any temperature you prescribe between 68° and 85°. The Melco "Natural Fog" Generator makes this possible.

Here is a unit that can convert any hospital room into a Humidity or Croup Room . . . a room that completely eliminates the adverse conditions of excessive heat and precipitation prevalent in existing Humidity Rooms.

Microscopic droplets of water are needed to penetrate the tiny filaments of the patient's respiratory system. When precipitation occurs, these droplets have agglomerated into clusters of water too large to reach and moisten the microscopic bronchioles which feed air to the patient's lungs.

The Melco "Natural Fog" Generator removes the large droplets by cooling, warming and recirculating the air. There is thus no chance for agglomeration. Without agglomeration there can be no precipitation. Without precipitation, true supersaturated humidity is administered to the patient. The physician prescribes the temperature . . . the patient remains cool, comfortable and dry.

IMPORTANT

A letter stating the dimensions of your present humidity facilities, or the room to be converted, will immediately bring you complete information and prices. Even if you are not contemplating a Humidity Room at the present time, we are sure that you will want this information in your files. Write Medical Equipment Division, Melchior, Armstrong, Dessau Co., Ridgefield, N. J.

Melco

Medical Equipment Division

MELCHIOR, ARMSTRONG, DESSAU CO.

OF DELAWARE INC.

RIDGEFIELD, NEW JERSEY

PARTIAL LIST OF DISEASES AND CONDITIONS WHERE THE USE OF HIGH HUMIDITY THERAPY WITH CONTROL OF TEMPERATURE MAY BE INDICATED

EXCESSIVE OR THICKENED BRONCHOPULMONARY SECRETIONS SUCH AS:

- neonatal asphyxia due to partial intrabronchial obstructions
- neonatal atelectasis
- cystic fibrosis
- asthma
- bronchitis
- lung abscess
- laryngotracheobronchitis
- pertussis
- bronchiectasis
- bronchopneumonia
- emphysema

SECRETIONS ALSO ACCOMPANYING:

- diaphragmatic paralysis due to poliomyelitis or encephalitis and pulmonary abscess
- general anesthesia
- thoracic surgery
- tracheotomy
- inhalation of noxious gases or dusts

ASPIRATION OF MATERIALS SUCH AS:

- foreign bodies
- gastric contents
- amniotic fluids

Write for complete information on how the Melco "Natural Fog" Generator can convert any hospital room into a Humidity Room capable of supplying supersaturated humidity with temperature control and without precipitation.

Melco

Medical Equipment Division

MELCHIOR, ARMSTRONG, DESSAU CO.

OF DELAWARE INC.

RIDGEFIELD, NEW JERSEY

outline form on a number of timely topics. A glossary and index complete this interesting and useful volume.—CLIFFORD WOLFE.

'Contract' science offers alternative to socialism

GOVERNMENT AND SCIENCE. Don K. Price, New York, New York University Press, 1954. 203 p. $3.75.

Hydrogen bombs, the National Institutes of Health and the Hill-Burton program all testify to the deep involvement of the federal government in science. In this book, the author traces the historical relationships of the federal government to science, scientists and the scientific method. He suggests that we are at a point in history when these relationships substantially alter not only the conduct of science in this country but many of the operations of the federal government as well.

Circumstances of the times, relates Mr. Price, have made it necessary for government to build with extraordinary rapidity upon these historical foundations during the last two decades. As a result, a new mechanism has been created for federal support of science.

This device, which the author calls "federalism by contract," involves the purchase of scientific services by government through the use of the administrative contract. It has been developed to satisfy two fundamental conditions. The first is the maintenance of scientific independence of institutions receiving financial support from the federal government. The second is the maintenance of accountability of government executives for government expenditures and programs.

The author concludes that this device is of such importance that it is a "workable alternative to socialism."

Hospital trustees and administrators who are concerned with the effect of federal money upon the independence of scientific institutions will find interesting reading in this series of essays.—JAMES P. DIXON, M.D., *health commissioner, City of Philadelphia.*

Rehabilitation literature

Rehabilitation Centers in the United States, published by the National Society for Crippled Children and Adults in 1953, was compiled by Henry Redkey of the Office of Vocational Rehabilitation from information submitted by 40 rehabilitation centers. There is a detailed description of the programs and finances of each of the centers, which have been divided into six arbitrary classes to facilitate discussion.

Information cited in this volume not only helps the reader to better understanding of the work of these centers, but can be useful to those who operate rehabilitation centers in comparing their own programs with the ones presented. The list of rehabilitation centers and their representatives in the appendix is a useful reference source.

A Survey of Sheltered Workshops, prepared by the Jewish Occupational Council of New York City in January 1954, is believed to be the first study of its kind. It was prepared in answer to the many inquiries received by the Council and its agencies.

This is the summarized report of the programs of sheltered workshops conducted by agencies in 11 major cities. Information on objectives of the programs, finances, duties and salaries of employees, type of work done, hours of work, etc., is presented partly in tabular form and partly through answers to specific questions. With this type of format, comparison of the work of the 11 agencies can be made very easily.

Sheltered Workshops and Homebound Programs, prepared in 1952 by New York's National Committee on Sheltered Workshops and Homebound Programs, sets down standards to assist agencies in organizing and continuing workshops for the handicapped. There is useful information on determining the need and the program, funds, public relations, safety precautions, establishing a market for the products, cost analysis and many other aspects of the successfully-planned and operated sheltered workshop program.

Braces, Crutches, Wheelchairs, the 1953 report by George G. Deaver and Anthony L. Brittis, is the fifth in the series of rehabilitation monographs published by the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center. It is an illustrated description of equipment used by persons with disabilities of the trunk and lower extremities, together with the methods of teaching them the use of these appliances.

Self-Help Devices for the Arthritic, number six in the above series of monographs, was authored by Edward W. Lowman, M.D. and published this year. This is an illustrated guide to devices that aid in the development of self-sufficiency in patients disabled by arthritis, through use of the devices or simply through training and practice. With each illustration, the name and address of the manufacturer of the device is given with the price. These devices are applicable not only to the arthritic but to many other types of disabled. These monographs can be ordered at $1 each from the publishers.—ELEANORE ROSPOND.

Committee common sense

COMMITTEE COMMON SENSE. Audrey R. and Harleigh B. Trecker. N.Y., Whiteside-Morrow, 1954. 158 p. $2.50

"We believe in the committee process as the only known alternative to one-man control of most organizations."

With this provocative statement as a springboard, the authors dive into their consideration of committees and what makes them work, and what conditions hamper committee accomplishments.

The book is written for the committee member equally as much as for the committee chairman. While giving full consideration to conditions encountered by such community committees as parent-teacher associations, community chests and others, this volume contains a great deal that is applicable to organizations with fulltime staffs. The use of subcommittees (go easy on appointing them); how to get a committee off to a fast, effective start; how to disband a committee; records and forms that can make *any* committee effective; and consideration of the chairman as a "helper" are some of the practical subjects treated.

The authors frankly admit that they do not have quick, easy answers to many committee problems, but where they feel they do have the answer, they offer it briefly and succinctly for the reader's consideration. — HOWARD F. COOK. ■

Where planning has meant –

more linen at half the cost

ROBERT J. DOBSON

IN PLANNING THE central laundry on Welfare Island, officials of the Department of Hospitals of the City of New York had to consider many things. The major factor was that this new plant was to replace an antiquated central laundry which had been producing insufficient linens for the six hospitals (5,848 beds) and nurses' residence to be served. This plant was housed in a 40-year-old building and poorly laid out, with obsolete equipment and no labor saving devices. Lighting and ventilation were necessarily very poor in such an old structure.

Some of our hospital administrators favored the individual laundries, admitting the high cost of production but stressing that individual laundries were needed for complete control of linen. Those administrators who favored centralized laundry were aware of the economy of a central laundry. They also appeared strongly in favor of passing the problems of laundry labor and other responsibilities to a manager outside the hospital.

LONG-RANGE PLAN

It was then decided to build a central laundry which, with proper management, would eliminate objections to central processing of linens for our hospitals. Comparatively speaking, the situation was no different from that of hotels, ships or other large users of linen supplies who contract for laundry outside their establishments.

Plans for this central laundry were made on a long-range basis to provide for an additional load anticipated from the new hospitals to be built after the war. Provisions were made to build a laundry with an initial capacity of 6,800 tons per year, with expansion to an ultimate capacity of 11,000 tons. Floor space was provided for the future equipment, so that each additional machine could be properly placed and coördinated with the other equipment for proper work flow.

The entire building has been designed for gravity flow. Incoming soiled laundry is brought by motor truck to the laundry and taken by elevator from a loading platform at street level to the third floor sorting and classifying room. It then moves via gravity feed from hoppers to washwheels on the second floor, then to extraction and into chutes to the first floor for final processing.

To our way of thinking, modern material handling is largely a matter of removing the element of manual labor. Lifting, pushing and hauling, for example, are done most efficiently and at least cost by machines. In such an industry as the hospital laundry, labor accounts for the lion's share of operating costs.

This meant that we would be required to use mechanized equipment, suitable for gravity flow, to the utmost in planning a new laundry. (In our smaller laundries, labor had run over 80 per cent of the cost, but in our Welfare Island plant labor represents only 68 per cent of the cost.)

Naturally, the floor space available to us was very important. We set up our basic requirements at ten square feet per bed served, with working aisles of nine feet in the wash room. All other aisles were set at six feet.

We designed the floor structurally to carry 250 lbs. per sq. ft. under the extractors and 150 lbs. per sq. ft. throughout the remaining space. Although a ceiling height of only 11 feet would have allowed us to use the monorail system, we went to a 14-foot height for better lighting and ventilation.

Another important factor we considered in planning was the particular type of service to be given. New York's Department of Hospitals cares for all types of patients; and in order to arrive at an estimated production capacity, we had to determine the number of general and chronic disease hospital beds to be served at our linen standard of 12 lbs. per patient day (some private hospitals with large nursing schools are using up to 16 lbs.). We had to calculate the number of tuberculosis beds at 7 lbs. and custodial beds at 3 lbs. per patient day. Since this figure indicated the total pounds to be processed, we started planning the laundry layout.

EQUIPMENT

We analyzed the pieces and pounds to be processed as against the hours the plant would operate, to determine the laundry equipment, operating machinery and floor space, as well as the steam,

Mr. Dobson is chief of the Division of Laundries, Department of Hospitals, New York City.

How A Prominent Chicago Hospital Increased Laundry Production Within Its Limited Space!

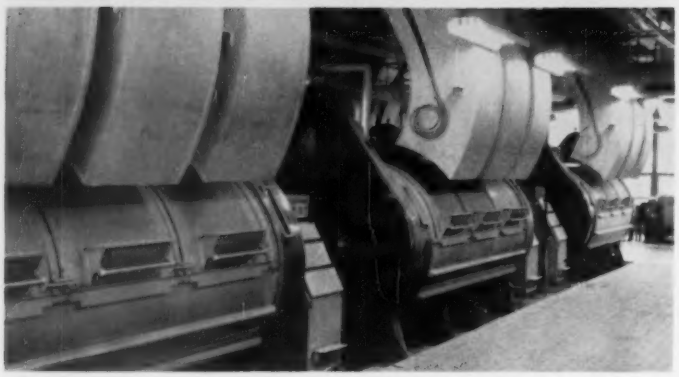
The PRESBYTERIAN HOSPITAL, one of Chicago's leading institutions, needed increased extraction capacity within a limited space. ZEPHYR famous HYDRAXTORS not only made good beyond expectations on these counts, but in addition they provided extraction with no increase in labor costs, no vibration, no balancing of load, less maintenance . . . all this and more, PLUS *LOWER INITIAL COST!*

Let us prove to you how Zephyr HYDRAXTORS will increase YOUR production in a minimum space with savings in labor, power, etc., at only a small initial investment. Send for complete information today.

HYDRAXTOR COMPANY

Division of ZEPHYR LAUNDRY MACHINERY COMPANY

153 WEST HURON STREET · CHICAGO 10, ILLINOIS · (Factory: 400 W. 21st St., Moline, Ill.)



Y POCKET washwheels (below) are hopper fed by gravity from floor above.

hot and cold water, electricity and compressed air required for the total operation.

Washwheels. Realizing that our total volume must go through the washing and extraction operation, the size and number of washwheels to be selected depended upon the size of the anticipated load and whether or not hopper feeding could be used. There were various types of washers available with cylinders ranging from 20″ to 60″ in diameter and 20″ to 126″ in length. Their load capacities ranged from 15 to 1,000 lbs. per load.

Our choice of type of cylinder also depended on our anticipated load (near 10,000 beds at present). The standard open pocket cylinder was the most widely used at that time. We had to determine whether to continue with this type or to use the Y partition, multiple pocket, large capacity per load machine. Since we intended to use hopper feeding, the choice was debatable at this point.

It was decided to use both the Y type and the open pocket unloading type. By using the Y type, it was felt originally that we could produce more poundage in less floor space with the large capacity per load machines. This actually has proved to be untrue because of the longer washing formula, the time element involved in loading and unloading and the many doors to be opened and closed.

We have found that a 42″ x 96″ unloading washwheel with a capacity of 400 lbs. is more advantageous than the larger 54″ x 108″ Y cylinder type manual unloading machine with a capacity of 700 lbs. The unloading washer takes approximately 2½ to 3 minutes to load and unload. The Y type takes from 15 to 18 minutes to load and unload, with an additional 10 to 15 minutes per load to wash the same type of linen. We realize two or three additional loads a day from the unloading machines, with more uniform quality.

Automatic Controls. We also had to consider accessories to the washwheels—thermometers, water gauges, washometers, automatic inlet and dump valves and the timers. We faced the problem of planning around manual, semi-automatic or fully automatic controls —and decided on the latter. Since then, we have found that fully automatic controls not only save supplies and obtain uniform quality, but they also enable our washmen to handle more machines than first planned. Originally, we had estimated that one washman and two helpers could handle six 42″ x 96″ unloading machines. We now have revised our plan upward to eight washers. It was necessary to install four 42″ x 36″ manually operated washers to handle our staff starch work.

Specific recommendations had to be set up. The hot and cold water pipe lines had to be large enough to fill the washers to the high water mark in a half-minute. Hot water would be 170° at the washers. The water did not exceed three grains of hardness: therefore, it was not necessary to put in softeners.

Heat Reclaiming System. A heat reclaiming system was installed. In this system, the waste water from the washer heats the incoming water before it goes to the hot water generator and storage tank. Since 60 to 65 per cent of the total water used is hot, we see a saving in fuel cost because a temperature rise of 40° or more is effected at no cost except interest on investment.

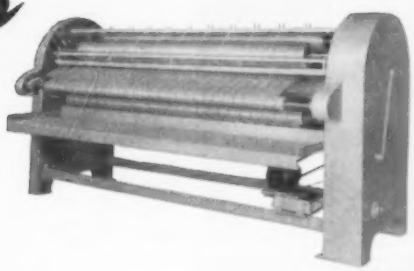
In our plant, where fully automatic controls are used, a central gravity feed soap and bleach system was installed. Gravity flow, of course, represents economy.

The three 1,000-gallon soap mixing tanks we use have a hand-operated hoist mounted on a monorail track, which carries soap and alkali containers from the floor to the tank, eliminating manual handling. A 60-gallon soap tank is placed in the staff section of the wash room. The supplies for this tank come through pipes from the central system.

Extractors. After setting up our wash room with the required number of washwheels, the extractor production had to be balanced against washer production. In order to do this, the rated capacity of the extractors and the number of loads that could be produced per hour had to be determined. Our selection, beyond this, was decided mainly by the plant layout and also by the fact that our plant

Know Your ABC's!

A Always
B Buy
C Chicago
D Dryer
E Equipment



IRONERS

WASHERS

DRYERS

EXTRACTORS

DESIGNED for HOSPITAL, HOTEL and INSTITUTIONAL LAUNDRIES

The Chicago Dryer Company has pioneered in the engineering and manufacturing of equipment particularly designed for your needs.

There are more Chicago Gas-Heated Flatwork Ironers in Institutional Laundries than any other brand. Ironers are available in gas, steam or electric heated. Chicago Cylinder and End Loading Washers, Extractors and Tumblers produce big volume with minimum maintenance and operating cost. Complete catalog on request.

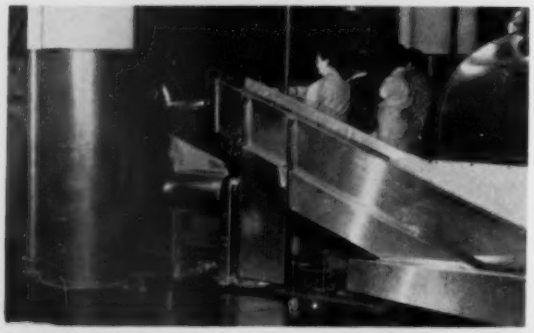
FLATWORK IRONERS • WASHERS • EXTRACTORS • DRYERS

Chicago DRYER CO.

EST. 1886 — 2224 North Pulaski Road • Chicago 39, Illinois

UNLOADING centrifugal extractors have removable basket to transport work via monorail. Space, rear, is allowed for expansion.

EIGHT-ROLL flatwork ironers (left in photo) are coupled with various labor saving devices.



SMALL pieces being fed through conditioning tumbler via conveyor belt in foreground.

DRYING tumblers—225 lb. capacity—have signalling device to notify operator when load is dry.

SPECIALIZED presses are provided for each type of garment processed. Automatic press timers will be installed at a later date.

is located in a building by itself.

We started out with the idea of providing 20 per cent more extraction capacity than washer capacity, to insure proper extraction in the event a shorter washing formula were adopted at a future date or an extractor broke down.

There were various types and sizes of extractors from which we could make our selection. We decided on the 54" centrifugal unloading type, equipped with a removable basket used to transport the work via monorail from washer to extractor and then, following extraction, to the finishing department. In our expansion program, we plan to use 60" extractors for better balance against the 42" x 96" washers. Two 30" extractors are used in the staff section of the wash room.

After deciding what type of washers and extractors we would use, we were then able to determine, by analysis, the percentage of total production that would be flatwork, rough dry, press work and blankets.

Ironers. Again, in selecting the flatwork ironers, we had to determine the anticipated load. We decided on eight-roll, 110" machines for sheets and eight-roll, 120" machines for medium and small pieces; and we coupled them with various labor saving devices. In our plant we use such accessories as conditioning tumblers, automatic sheet folder, small piece feeder and spreader for five lanes of operation, as well as a stacker for catching the small pieces, a small piece folder and conveyors. Our future plans call for sheet spreading devices and additional conveyors. A pressure of 125 lbs. of steam is provided at the flatwork ironer and 100 lbs. at all other equipment to insure maximum production.

Drying Tumblers. The fluff dry or tumbled work was the next volume to consider. We had a choice of drying tumblers ranging in size from 20 lbs. to approximately 225 lbs. per load. At that time, we selected the larger machine—capacity 225 lbs.—which had proved successful in other plants. Today's thinking, however, is toward a smaller 100 lb. capacity machine, with which I agree: it has the advantages of flexibility

and economical operation. Automatic signalling devices were installed to notify the operator when the load is dry.

Pressers. Any laundry processes in its pressing department the smallest percentage of the finished work at the greatest cost per operator per pound. Analysis of the approximate number of pieces to be finished in this department was very important to our planning; otherwise, it would have been impossible for us to determine how many or what type of presses would be needed.

In our planning, we used specialized units for each type of garment to be processed—coats, aprons, pants, female uniforms, shirts, etc. These specialized units were arranged so as to operate efficiently and produce quality work with a minimum of hand ironing. Facilities for hand ironing were provided, of course, but not for general use. Our future planning calls for press timers which open the press automatically when proper ironing is completed.

Miscellaneous. A special department on the first floor is devoted to washing, extracting, drying and processing of blankets and curtains.

Other miscellaneous equipment had to be installed, including marking machines, soiled linen hoppers to washers, monorail system, starch cookers, sewing and button machines, platform scales, blanket and curtain dryers, repair equipment tables, chutes for gravity flow and sorting bins.

REWARDS OF PLANNING

Since the laundry was put into operation on Jan. 3, 1950, we have increased our production from 3,545 tons in the first year to 7,180 tons in 1953. We are now processing in excess of the manufacturer's rated production, with the help of a small night shift.

Plans for the expansion of this laundry are being prepared to carry the anticipated added load. We are now serving seven metropolitan hospitals ranging in size from 275 to 3,082 beds and totalling nearly 10,000 beds in all, as previously noted.

After five years of operation of the departmental laundry, the administrators of the hospitals concerned have, on the whole, been satisfied with the laundry arrangement. One expression of discontent —which prevents our citing a record of 100 per cent satisfaction—is the occasional misdirection of a bag of linen in delivery. When the millions of pounds produced are taken into consideration, however, the few bags involved represent a very small percentage of error.

The department's monthly cost and production reports indicate that the cost per pound is only half, or sometimes one-third, that of the individual laundries. It would naturally be expected that the departmental laundry, with the latest automatic equipment, gravity flow of work, bulk handling, group supervision and centralized management, would show a savings, but our experience has exceeded our expectation. It might also be noted that, after five years of operation, the departmental laundry is still improving production, which is lowering the cost still further. ■

ICE—AT ANY HOUR!

MODEL XV WITH ACCESSORIES

THE GENNETT ICE CART

Designed for versatile service, the Model 15 packs 150 pounds of flaked, cubed or chipped ice. Ideal for numerous hospital and institutional assignments.

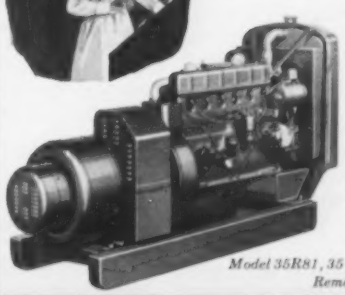
GENNETT ICE CARTS are constructed of stainless steel, in a variety of four models. Model 15 stands 40½ inches and is equipped with pneumatic tires.

WRITE US FOR SPECIFICATIONS, PRICES.

GENNETT AND SONS, INC.
MANUFACTURERS
ONE MAIN STREET PHONE 2-2151
RICHMOND, INDIANA

KOHLER Electric Plants
...stand-by protection when central station power fails

In hospitals and sanitariums, stand-by Kohler Electric Plants insure uninterrupted use of nurses' call bells, operating room and exit lights, elevators, baby incubators, X-rays, iron lungs, sterilizers. Take over critical loads automatically. Install *before* storm or accident causes emergency! Sizes 1000 watts to 35 KW, gasoline and Diesel. Write for folder D-17.



Model 35R81, 35 KW, 120/208 volt AC. Remote starting.

Kohler Co., Kohler, Wisconsin. Established 1873

KOHLER OF KOHLER

PLUMBING FIXTURES • HEATING EQUIPMENT
ELECTRIC PLANTS • AIR-COOLED ENGINES • PRECISION CONTROLS

personal news

● REV. C. M. AUSTIN, superintendent of Sioux Valley Hospital, Sioux Falls, S. D., was recently awarded the 1954 distinguished service medal by the Cosmopolitan Club in recognition of his many years of service as the hospital's superintendent and his promotion of the welfare of crippled children.

A member of the American College of Hospital Administrators, Reverend Austin is a past president and former chairman of the rate committee of the South Dakota Hospital Association.

● ANN BLAND, administrative assistant at Mound Park Hospital, St. Petersburg, Fla., has been appointed consultant with the hospital planning division, Florida State Improvement Commission, Tallahassee.

A graduate of Northwestern University course in hospital administration, Miss Bland completed her administrative residency at the St. Petersburg hospital. She is a member of the American Hospital Association.

● GEORGE M. BREWER, former administrator of Roosevelt General Hospital, Portales, N.M., has been appointed administrator of the Los Alamos (N.M.) Medical Center. THOMAS J. HARTFORD JR. succeeds Mr. Brewer at the Portales hospital.

A past president of the New Mexico Hospital Association, Mr. Brewer formerly served as administrator of Hansford County Hospital, Spearman, Texas. He is currently serving as a member of the board of directors of Hospital Service, Incorporated (Blue Cross), Albuquerque.

Mr. Hartford was formerly associated with Walter Reed Army Medical Center, Washington, D.C., and Brooke Army Medical Center, Fort Sam Houston, Texas.

● ELIZABETH BRUMFIELD, R.N., administrator of Jackson County Hospital, Pascagoula, Miss., recently resigned her position but will continue to serve the hospital as superintendent of nurses. I. P. PAINTER succeeds Mrs. Brumfield as administrator.

● P. ARTHUR CAPITANELLI, assistant director of the methods improvement program at St. Luke's Hospital, Chicago, has been appointed assistant director of Presbyterian Hospital, Chicago. Prior to his Chicago affiliation, Mr. Capitanelli had served as registrar at the Veterans Administration Hospital, Sunmount, N. Y., for four years.

MR. CAPITANELLI

A member of the American Hospital Association, Mr. Capitanelli received his master's degree in hospital administration from Northwestern University.

● CLAUD CLARK JR., administrator of Washington County Hospital, Chatam, Ala., has been appointed administrator of Pearl River County Hospital, Poplarville, Miss. Mr. Clark succeeds HAROLD PITTMAN, who is now administrator of State Tammany Parish Hospital, Covington, La.

● HARRY C. SMITH, administrator of Wesley Hospital, Oklahoma City, from 1940-52, has been named administrator of the new Southern Oklahoma Memorial Hospital, Ardmore, scheduled to open the fifteenth of this month.

● WILLIAM E. SHEPPARD has been appointed assistant superintendent of Friends Hospital, Philadelphia.

● ALICE DECANIO has been named administrator of the new Memorial Hospital, Claremore, Okla.

● CYRUS EAVES has resigned as administrator of George County Hospital, Lucedale, Miss. No successor has been named.

● JAMES M. EDWARDS, former business manager of Leeds (Ala.) Hospital, has been appointed director of Emanuel County Hospital, Swainsboro, Ga. He succeeds MAJ. A. S. WALEA, who has retired.

Mr. Edwards is a recent graduate of the University of Georgia program in hospital administration.

● LOUISE ESCH, assistant superintendent of Stanford University Hospitals, San Francisco, recently resigned her position to join the staff of DR. ANTHONY J. J. ROURKE, hospital consultant of New Rochelle, N. Y.

A graduate of the University of Oklahoma, Miss Esch served as director of dietetics at Stanford University Hospitals from 1940-54. A nominee in the American College of Hospital Administration, Miss Esch holds membership in the American Hospital and Dietetic Associations.

● ROBERT L. DENHOLM, acting director of hospitals at the University of Colorado Medical Center, Denver, has been appointed director of hospitals.

MR. DENHOLM

Mr. Denholm is a graduate of the Northwestern University course in hospital administration.

● GERTRUDE R. FOLENDORF, R.N., has retired as administrator of Shriners' Hospital for Crippled Children, San Francisco, after 31 years of service. Twenty years of that time she served as director of all 17 Shriners' Hospitals in North America and Hawaii. MARGUERITE PECK, a member of the hospital's staff, succeeds her as administrator.

The nationally-known leader in the orthopedic care of crippled children, Mrs. Folendorf is a past president of the California State Nurses Association and California State Board of Examiners. A fellow in the American College of Hospital Administrators, Mrs. Folendorf is a past president of the College.

In 1953 the College cited her for "the completion of a notable career in hospital administration," when she relinquished her duties as national administrator of Shriners' Hospitals. Upon her recent resigna-

If the Voluntary Hospital is essential to Our Way of Life

And we believe it is ...

Its Support must be a pleasure!

People will not long work on a distasteful job!

We strive to make the campaigns we direct a source of satisfaction and a real joy to the thousands of volunteer workers who make success possible. The essence of a good fund-raising campaign is the creation of good public relations.

fund-raising counsel to hospitals exclusively

CHARLES A. HANEY & ASSOCIATES

259 WALNUT STREET, NEWTONVILLE 60, MASS.

Telephone LAsell 7-6223

tion, a scroll was presented to her by the board of trustees of Shriners' Hospitals, in recognition of her service to hospitals and to the care of crippled children.

● DONALD L. FORD, research associate with the Hospital Council of Philadelphia, has been appointed administrative assistant at the Children's Hospital of Philadelphia.

● HAROLD L. GANO, former administrative resident and assistant at Norton Memorial Infirmary, Louisville, Ky., has been appointed administrator of the Carmi (Ill.) Township Hospital. Mr. Gano succeeds PAUL X. ELBOW, who is now assistant administrator of Borgess Hospital, Kalamazoo, Mich.

A member of the American Hospital Association, Mr. Gano received his master's degree in hospital administration from the University of Chicago.

● JOHN A. HARRISON has been named assistant administrator of Truesdale Hospital, Fall River, Mass. He succeeds DONALD C. BILHORN, who is now administrator of the John T. Mather Memorial Hospital, Port Jefferson, L. I., N. Y.

A graduate of Columbia University, Mr. Harrison completed his administrative residency at Newton-Wellesley Hospital, Newton Lower Falls, Mass.

● SISTER M. JOHANNA has been appointed sister superior of St. Francis Hospital, Evanston, Ill. Sister Johanna replaces SISTER M. STEPHANINA, who has been serving as both superior and administrator, but will now devote her fulltime to administration.

● RODNEY J. LAMB has been named administrator of the Ernest V. Cowell Memorial Hospital, Berkeley, Calif. Mr. Lamb succeeds THOMAS E. TONKIN, who is now administrator of Peninsula Community Hospital, Carmel, Calif.

A recipient of a master of public health degree from the University of California, Mr. Lamb served his administrative residency at Peninsula Hospital, Burlingame, Calif. He is a member of the American Hospital Association.

● RICHARD M. LOUGHERY, assistant administrator of Garfield Memorial Hospital, Washington, D. C., has been appointed administrator of the hospital. Mr. Loughery succeeds LEO G. SCHMELZER, who is now administrator of the Wilmington (Del.) General Hospital.

MR. LOUGHERY

Before joining Garfield Memorial Hospital in February 1953, Mr. Loughery served Methodist Hospital, Indianapolis, as personnel director and then as senior administrative assistant.

A member of the American College of Hospital Administrators, Mr. Loughery also holds membership in the American and Maryland-District of Columbia-Delaware Hospital Associations.

● HERBERT N. MORFORD, administrator of the Hospital of the Good Shepherd, Syracuse, N. Y., since 1947, has resigned to accept the position of assistant executive secretary of the American College of Physicians in Philadelphia.

Mr. Morford formerly served as director of Overlook Hospital, Summit, N. J.; Litchfield County Hospital, Winsted, Conn. and Prospect Heights Hospital, Brook-

New Safety!

Explosion-Proof

PORTABLE EYE MAGNET

The powerful, dependable Lancaster Eye Magnet has been redesigned by our engineers and is now the first—*the only*—portable eye magnet completely explosion-proof—*completely safe*—for use in any operating room in the presence of explosive atmospheres. (Patent Applied For.) It is noiseless, requires no "warming up" period. The single control is the momentary contact, explosion-proof footswitch. Complete in sturdy black leatherette covered case, with 3 interchangeable silvered probe tips, two sterilizable cloth sleeves, necessary wrenches, utility tray. For 115 volts, AC only.

V. Mueller & Co.

330 SOUTH HONORE STREET CHICAGO 12, ILLINOIS

Branches Now In

DALLAS, TEXAS — ROCHESTER, MINN. — HOUSTON, TEXAS

You Can Bank on BEAUTY WHITE for QUALITY... for SAVINGS!

COLGATE'S
BEAUTY WHITE TOILET SOAP
Hard Milled to Last Longer!

- ★ Finest Quality Soap! ★ Utmost in Economy!
- ★ Gives Abundant Lather in All Types of Water!
- ★ Same Base and Same Pleasing Fragrance as Colgate's Floating Soap!

Packed unwrapped for your convenience
1½ oz.—300 in a case • 3 oz.—144 in a case.
Available special wrapped only, ½ oz.—1000 in a case.

FOR YOUR PRIVATE PAVILION

PALMOLIVE SOAP is MILD and GENTLE—the mildest soap of all! Proved milder than America's other leading toilet soaps and white "floating" soaps. Write for information about hospital sizes, prices, etc.

FREE! New 1955 Handy Soap and Synthetic Detergent Buying Guide. Tells you the right product for every purpose. Ask your C.P. representative for a copy or write to our Ind. Dept.

Colgate-Palmolive Company

Jersey City 2, N. J. • Atlanta 5, Ga. • Chicago 11, Ill.
Kansas City 5, Kans. • Berkeley 10, Calif.

lyn, N. Y. He has also held the post of administrator at Franklin Square Hospital, Baltimore.

A fellow in the American College of Hospital Administrators, Mr. Morford is a member of the American Hospital Association.

● JEAN M. OAKES is the new assistant director of Chester County Hospital, Philadelphia.

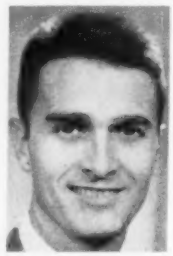
● FRANK L. PORTER and JAMES E. CRANK have been appointed assistant administrators of the Jefferson-Hillman Hospital, Birmingham, Ala.

A graduate of Columbia University's course in hospital administration, Mr. Porter served as administrative resident and assistant administrator at Episcopal Hospital, Philadelphia. He is former administrator of General Hospital, Saranac Lake, N.Y.

A nominee in the American College of Hospital Administrators, Mr. Porter holds membership in the American and Alabama Hospital Associations and the Birmingham Hospital Council.

A recipient of a master of public health degree in health administration from the University of North Carolina, Mr. Crank formerly served as assistant to the director of local health organizations for the Georgia Department of Public Health. He is a member of the American Hospital and Public Health Associations and the Birmingham Hospital Council.

● JOSEPH K. OWEN, assistant director of the hospital division and associate professor of hospital administration at the Medical College of Virginia, Richmond, was recently awarded a doctorate in philosophy with a major in hospital administration from the State University of Iowa. He received his master's degree in hospital administration from Columbia University.



MR. OWEN

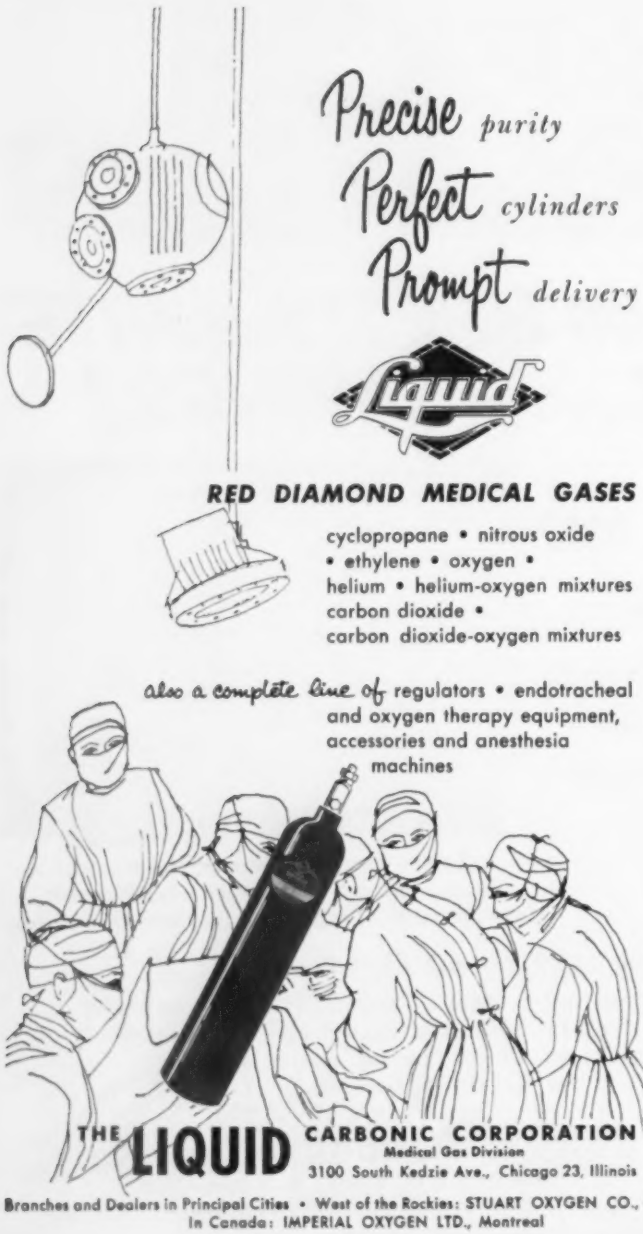
Mr. Owen is a nominee in the American College of Hospital Administrators and a member of the American Hospital Association.

● DR. ANTHONY J. SANTANGELO, staff physician at Mississippi State Hospital, Whitfield, has been appointed director of the East Mississippi State Hospital, Meridian. He replaces DR. VICTOR J. BEAN.

● DR. RAY E. TRUSSELL, founding director of Hunterdon Medical Center, Flemington, N. J., has been appointed the first executive officer of the newly-organized School of Public Health and Administrative Medicine at Columbia University. Dr. Trussell was also named DeLamar professor of administrative medicine and associate dean for public health in the faculty of medicine.

Prior to his new appointments, Dr. Trussell also had been serving as clinical professor of preventive medicine at the New York University-Bellevue Medical Center, New York City.

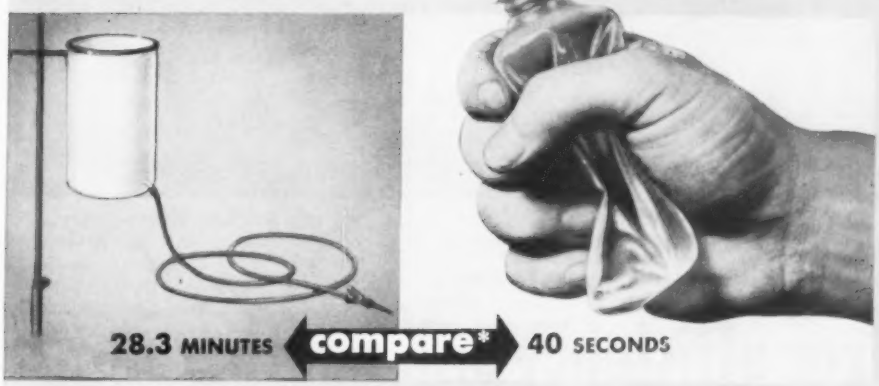
After receiving his medical degree from the University of Iowa, Dr. Trussell served an internship at University Hospital in Iowa City where he later returned to become an instructor in the Department of Preventive Medicine at the University of Iowa. He was awarded his master of public health degree in 1947, the same year that he became a Rockefeller Foundation Fellow of Johns Hopkins School of Public Health.


Precise purity
Perfect cylinders
Prompt delivery
Liquid
RED DIAMOND MEDICAL GASES
cyclopropane • nitrous oxide
• ethylene • oxygen •
helium • helium-oxygen mixtures
carbon dioxide •
carbon dioxide-oxygen mixtures
also a complete line of regulators • endotracheal
and oxygen therapy equipment,
accessories and anesthesia
machines
THE LIQUID CARBONIC CORPORATION
Medical Gas Division
3100 South Kedzie Ave., Chicago 23, Illinois
Branches and Dealers in Principal Cities • West of the Rockies: STUART OXYGEN CO., Los Angeles
In Canada: IMPERIAL OXYGEN LTD., Montreal

When you save TIME
you save MONEY

FLEET ENEMA *Disposable Unit*

NOW AT A NEW, LOWER PRICE



It takes only *40 seconds* to prepare and administer a routine enema with the Fleet Enema Disposable Unit. Using cumbersome, old-fashioned equipment, preparation plus instillation plus "clean-up" and sterilization consumes *28.3 minutes.*

Only FLEET ENEMA Disposable Unit *offers these conveniences* . . . one hand administration . . . sanitary, individually sealed rectal tube . . . built-in rubber diaphragm to control flow, prevent leakage.

Each individual 4½ fl. oz. unit contains, per 100 cc., 16 gm. sodium biphosphate, and 6 gm. sodium phosphate, an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.

**From a soon-to-be-published time-cost study.*

"Phospho-Soda", "Fleet" and "Fleet Enema" are registered trademarks of C. B. Fleet Co., Inc.

C. B. FLEET CO., INC. • LYNCHBURG, VIRGINIA

Manufacturers of "Phospho-Soda", a laxative of choice for over half a century.

Nurses are enthusiastic about Castle's new 3-minute Emergency Instrument Sterilizer. Engineers say its all-welded Monel construction...

ups sterilizer efficiency still another notch

You get no corrosion inside these modern sterilizers. They're solid Monel®.

You get no chipping. No peeling. Units heat fast, clean easily. Their safety is extremely high. Their life is long. They aren't harmed by saline or other hospital solutions.

Efficiency keynotes Resurrection's bulk units, too. Like the cylindricals, they were also supplied by Castle and have many of the same features. For economy, Castle makes them of Nickel-Clad Steel.

Now, for the outside, too

Engineers know that when inner and outer shells are different metals, they expand and contract at different rates. Monel has proven beyond question its value as an inner shell material. So now, Castle makes the outer shell and end ring (door collar) of Monel, too. Solid Monel. Then they weld all three into one solid unit that stays tight.

You reap the benefits. Corrosion resistance throughout. Long life.

Notice the other features of these Castle units

The photographs here show recent Castle installations at Chicago's new Resurrection Hospital... the 3-minute unit, top right... a 30-minute unit, top left... a Nickel-Clad Steel bulk unit in the small photo. Examine them closely. Notice the self-centering doors, the easy-to-use, clear reading Thermatic Control. Notice, too, the Monel trays.

For detailed information on these units and other new designs, write Wilmot Castle, Rochester 18, New York. Or call their local office.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street New York 5, N. Y.

INCO NICKEL ALLOYS

Monel ... for low maintenance sterilizers

Reaffirms Voluntary Method of Meeting Health Problems

OFFICIAL NOTES

The following are actions taken by the Board of Trustees of the American Hospital Association at its meeting in Chicago, February 2-3:

HEALTH LEGISLATION

***VOTED:** To appoint a committee composed of Dr. Lucius R. Wilson, J. Douglas Colman and Kenneth Williamson to study the new reinsurance bill when it is made public and to submit recommendations as a basis for establishing Association policy.*

***VOTED:** To favor the principle of federal grants to aid a program of assistance to state and local governments to pay for the health care of indigents, with the understanding that the administration of such grants would be compatible with Association policy.*

***VOTED:** That the American Hospital Association aggressively support appropriate legislation for mental health.*

***VOTED:** To give approval to the development of legislation for vocational training which would provide aid for the training of ancillary personnel for patient care.*

(Tol Terrell and John N. Hatfield registered negative votes on the foregoing proposition.)

***VOTED:** That the American Hospital Association is opposed at this time to federal grants for scholarships to undergraduate nurses.*

***VOTED:** That the American Hospital Association favors the government selling surplus properties on which substantial recovery can be made. However, when no substantial returns can be had on property useful for health and educational purposes, it is the recommendation of the Association that such properties be donated to nonprofit hospitals and educational institutions.*

***VOTED:** To reaffirm the position taken by the American Hospital Association in February and March 1949 in statements to both House and Senate committees of the 81st Congress, urging the retention of the exemption of hospitals from the provisions of the Taft-Hartley Act.*

(Continued on page 178)

Further details of President Eisenhower's health program have been provided by his health message (deferred a week by the Formosan crisis).

The message was delivered on January 31 and background information on the proposals was given a day later by Oveta Culp Hobby, secretary of the Department of Health, Education and Welfare.

There were no surprises in the President's program or in Mrs. Hobby's arguments for his proposals. The President said that good health was a proper national concern "because the strength of our nation is in its people."

He also said:

"As a nation, we are doing less than now lies within our power to reduce the impact of illness. Many of our fellow Americans cannot afford to pay the costs of medical care when it is needed, and they are not protected by adequate health insurance. Too frequently, the local hospitals, clinics or nursing homes required for the prevention, diagnosis and treatment of disease either do not exist or are badly out of date. Finally, there are critical shortages of the trained personnel required to study, prevent, treat and control disease."

Editorial comment on the legislative proposals will be found on page 68 of this issue.

Both the President and Mrs. Hobby espoused the voluntary method of meeting these problems. The President said all his proposals "recognize the primacy of local and state responsibility for the health of the community. They encourage private effort, with private funds."

Mrs. Hobby said, "The underlying concept is one of shared responsibility among the many groups and individuals who contribute to the nation's health."

Here are the major proposals contained in the Administration health message:

REINSURANCE

A $100-million, self-supporting fund, starting with $25 million this year, to reinsure voluntary health plans in the following categories:

Policies for average and lower income families with broader protection against hospital costs and physicians' services, in hospital, office or home.

Policies against exceptionally costly illnesses, the catastrophic coverage.

Policies for rural families.

Policies in other areas which promise to enlarge the scope of voluntary health insurance or improve its benefits.

In her arguments for reinsurance, Mrs. Hobby said "It is not a cure-all. There is no magic in the proposal." But she insisted that it could provide more and better health insurance if two "ifs" were realized: if the proposal is passed by Congress and if it is used by the organizations that write insurance.

HEALTH FACILITIES

The Administration proposed to guarantee mortgages for construction of certain health facilities upon payment of a premium of up to one per cent.

The Hill-Burton program, as extended by the last Congress, has limitations, according to the Administration's statements. The limitations on ownership rule out special clinics for ambulatory patients unless operated by a nonprofit hospital or public agency and also rules out proprietary facilities.

The Administration recommended mortgage insurance, therefore, on loans to all types of sponsors, except state or local units of government. It foresaw the following major groups as potential users: hospitals, private medical clinics, coöperative groups, community-sponsored facilities and nursing homes.

The President's budget message called upon Congress to authorize $65 million for construction under the basic Hill-Burton program and $60 million, the maximum, for

(Continued on page 174)

Adopt Program to Evaluate Foreign Doctors

A proposed program to evaluate the qualifications of graduates of foreign medical schools seeking entrance to the United States was approved in principle by the Federation of State Medical Boards at the Congress on Medical Education and Licensure held in Chicago last month.

The purpose of the program is to identify qualified candidates and eliminate unqualified ones so that only those comparing favorably with graduates of American schools assume direct responsibility for the care of patients.

Prior to the action of the Federation, the three other groups comprising the Coöperating Committee that developed the program accepted the program in principle. These were the Association of American Medical Colleges, the American Medical Association's Council on Medical Education and Hospitals and the American Hospital Association.

Participating in a panel discussion during the Congress, Dr. Edwin L. Crosby, AHA director, stated that the AHA Board of Trustees had approved the program in principle and had instructed and authorized representatives to participate actively in its development.

The Coöperating Committee will work out the mechanisms of the program and these details will then go back to the groups concerned for approval before the program becomes effective.

The plan envisions the establishment of a central administrative unit, provides for the evaluation and verification of foreign physicians' credentials and describes a preliminary examination in the basic medical sciences and the major clinical sciences the foreign graduate must take and pass before coming to the United States.

Foreign-trained physicians must have 18 years of total formal education including a minimum of 32 months of direct study of medicine, excluding time devoted to what is considered in the United States as premedical study. They must show evidence of satisfactory completion of their courses and of acceptible moral and ethical behavior.

American citizens who have studied abroad would have to fulfill these requirements and in addition, produce evidence of satisfactory completion of at least three years acceptable premedical study in the United States. Some consideration might be given displaced persons who can not obtain original credentials.

Preliminary thinking envisions certification of credentials and successful completion of the preliminary examination as essentials to be met before appointment of a foreign-trained physician to any internship or residency.

A further step in the proposed program calls for a comprehensive examination for all foreign-trained physicians who seek licensure. Successful completion of all steps in this program would result in certification of the applicant to the state examining board for its consideration.

Dr. W. S. Middleton Named VA Chief Medical Director

Dr. William S. Middleton, dean of the University of Wisconsin Medical School since 1935, has been appointed chief medical director of the Veterans Administration, according to a recent announcement by Harvey V. Higley, administrator of Veterans affairs. Dr. Middleton succeeds Vice Adm. Joel T. Boone, MC, USN (Ret.), who resigned his position, effective February 28, because of ill health and his desire to retire from public service.

Dr. Middleton, an overseas veteran of both World Wars, has been associated with the veterans medical program in part-time consultative capacities since 1922 when he served the United States Veterans Bureau as an attending specialist in tuberculosis. He was one of the original members of the Veterans Administration Medical Advisory Group and currently is serving as a member of the national VA Medical Advisory Committee on Education. He is chairman of the dean's committee affiliated with the Veterans Administration Hospital, Madison, Wis.

A native of Norristown, Pa., Dr. Middleton received his medical degree from the University of Pennsylvania in 1911. Following his internship at Philadelphia General Hospital, he joined the staff of the University of Wisconsin Medical School, where he has served as instructor in clinical medicine, assistant and associate professor, and lastly, as dean of the medical school for the past 20 years,.

A past president of the American College of Physicians, Dr. Middleton is an honorary fellow in the

DR. MIDDLETON

Royal Society of Medicine and the Royal College of Physicians (London) and a member of the American Medical Association.

Mr. Higley also praised Admiral Boone's four-year stewardship of the VA medical program as being "of the utmost value to the nation and its sick and disabled veterans."

Association to Publish Annual Listing of Hospitals

A letter concerning registration of hospitals was sent to all hospitals on January 20 by Dr. Edwin L. Crosby, director of the American Hospital Association, and Dr. George F. Lull, general manager of the American Medical Association.

The letter follows:

"On recommendation of the Council on Medical Education and Hospitals, and on approval by the Board of Trustees, the House of Delegates of the American Medical Association at its annual session in San Francisco on June 23, 1954, voted to discontinue hospital registration as a Council function (*The Journal of The American Medical Association*, July 17, 1954, pp. 1073-74).

"The Joint Commission on Accreditation of Hospitals was requested to undertake registration of hospitals in addition to its present accreditation activities. The Joint Commission did not accept this function, however, as it felt

(NO. 20-62 PRIVATE ROOM GROUPING. THIS GROUPING ALSO RECOMMENDED FOR SEMI-PRIVATE ROOMS AND WARDS)

Hill-Rom No. 62

MOTOR-DRIVEN HILOW BED

APPROVED FOR USE WITH OXYGEN

LISTED UNDER REEXAMINATION SERVICE UL UNDERWRITERS' LABORATORIES, INC.

UNDERWRITERS' LABORATORIES, INC.

HAS BEEN APPROVED BY UNDERWRITERS' LABORATORIES, INC. FOR USE WITH OXYGEN

● The Hill-Rom No. 62 motor-driven Hilow Bed, shown in the above room grouping, has been approved by Underwriters' Laboratories, Inc., for use with oxygen administering equipment of the nasal, mask type, and ½ bed length oxygen tents. This bed, which had previously been the first bed of its type to be approved by Underwriters' for use under normal conditions, now becomes the first such bed to be approved for use with oxygen. Write or wire for further information.

Other items shown in the above room scene are: No. 2003 Bedside Cabinet, No. 20-614 Overbed Table, No. 2004 Dresser Base with No. 20-05 Mirror, No. 2008 Arm Chair, No. 20-07 Straight Chair, and No. 305 Lamp.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

for semi-private rooms, wards, recovery rooms, etc.

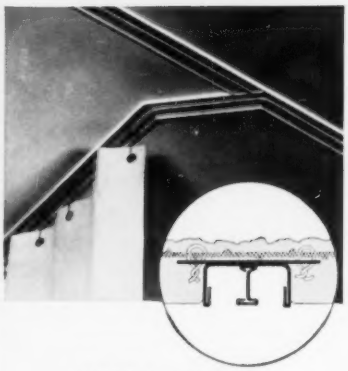
easily installed, quiet in operation — gives complete privacy

For years, Hill-Rom Perfected Screening has been preferred by hospital officials because of its ease of installation, minimum maintenance costs and worries. Doctors and nurses like Perfected Screening because of its smooth, quiet operation and the fact that there are no floor obstructions to interfere with their work.

Hill-Rom "Near-Ceiling" Screening, as the name implies, permits the installation of the track close to the ceiling, out of the normal range of vision and quite inconspicuous when the curtains are not in use. Even for older buildings with high ceilings, standard units of Near-Ceiling Screening are available with longer support rods to compensate for the extra ceiling height.

NOW . . . for

New Construction and Remodeling Jobs



HILL-ROM Recessed-in-Ceiling Screening

- No Rod Supports
- No Wall Brackets
- Exclusive I-Beam Track

Hill-Rom recessed-in-ceiling Perfected Screening provides for insertion of the track directly into the ceiling, leaving no exposed fixtures or projections. Designed primarily for use in new construction, or when remodeling is being done. The track is wired directly to the metal lath and stringers—before plastering. Plaster is applied flush with the track. Channel and track may be painted to match ceiling finish, making an installation that is hardly noticeable. This type of screening can also be used with accoustical tile applications.

STANDARD CURTAINS

By using the standard Hill-Rom screening unit (either type) one-size curtains are used throughout the building. This eliminates confusion when replacing curtains after laundering. Hill-Rom curtains are made of pre-shrunk, vat-dyed Cordette material, in 16′ width, length determined by ceiling height. The rollers are made of machined nylon, insuring quiet operation. Rollers and curtain hooks are assembled in one unit.

STANDARD UNITS—ALL READY TO INSTALL

Both types of Hill-Rom Perfected Screening, Near-Ceiling and Recessed-in-Ceiling, are available in standard units complete with all component parts, ready to install. These standard units permit the proper screening of all sizes and shapes of rooms without special drawings or special tools. Write for booklet giving complete information on both of these types of Perfected Screening.

HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

Sharpness...

Rigidity...

Strength...

SHARP *Micrometrically uniform sharpness* throughout entire length of cutting edge. *Correctly ground and honed* cutting edge insures easier incisal penetration.

RIGID Scientifically controlled by the handle blade-lock. Full compensation for lateral pressure needs of surgical procedures.

STRONG Superior surgical steel produced by exclusive A.S.R. processes supply unusual strength to 'Command Edge' blades. These blades have keener, longer lasting edges. They meet all exacting surgical performance requirements.

A.S.R. PRECISION PRODUCTS

ORDER TODAY through your dealer

Flushaway
BED-PAN COVERS

ECONOMICAL
SANITARY
DURABLE
ADAPTABLE
DISPOSABLE

by A·S·R

AMERICAN SAFETY RAZOR CORPORATION
HOSPITAL DIVISION
380 MADISON AVE. NEW YORK 17, N. Y.

that such action might create a double standard of approval in the minds of the medical profession and the public.

"The Board of Trustees of the American Hospital Association, recognizing the importance to hospitals of registration and of statistical information resulting from registration, voted to carry on these programs without interruption. It will publish a listing of hospitals meeting criteria established by the American Hospital Association, together with statistical data relating to hospitals, in the Administrators Guide issue of HOSPITALS magazine. Hospitals registered by the Council on Medical Education and Hospitals at the time of discontinuation of registration will be included in this listing. The listing will be published annually and will replace registration by the Council. The Joint Commission on Accreditation of Hospitals will accept this listing instead of registration as prerequisite for accreditation. The hospital number of *The Journal of The American Medical Association* will no longer be published.

"The Council on Medical Education and Hospitals will continue to function in the program of internship approval, in the approval of residencies in collaboration with the specialty boards and in the approval of technical schools. All inquiries regarding future listing of hospitals should be addressed to the American Hospital Association, 18 E. Division St., Chicago, Ill."

Dr. Letourneau To Head Program at Northwestern

Dr. Charles U. Letourneau has been appointed director of the program in hospital administration at Northwestern University, effective April 1.

Dr. Letourneau has resigned his post as secretary of the Council on Professional Practice of the American Hospital Association, a position he has held for four years.

Dr. Letourneau is a graduate in medicine and the law, taking his degrees at McGill University. He is also a graduate of the Northwestern course which he now heads.

He served for seven years in the Royal Canadian Army Medical Corps, being discharged with the rank of colonel, and from 1946 to 1950 was superintendent of the Queen Mary Veterans' Hospital in Montreal.

Rev. C. C. Rasche, New APHA President

NEW OFFICERS of the American Protestant Hospital Association and the 1955 president of the Association of Protestant Hospital Chaplains, elected at the Association's three-day conference in Chicago last month, are (from left): APHC president, Rev. Frederic M. Norstad, director, chaplaincy services, Lutheran Welfare Society of Minnesota, Minneapolis; APHA president-elect, Frank Prentzel Jr., administrator, Methodist Hospital, Philadelphia; president, Rev. Carl C. Rasche, administrator, Evangelical Deaconess Hospital, St. Louis; immediate past president, C. E. Copeland, administrator, Missouri Baptist Hospital, St. Louis; treasurer, L. B. Benson, administrator, Bethesda Hospital, St. Paul, Minn. and executive director, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, Ind. Second vice president, Paul R. Hanson, administrator, Emanuel Hospital, Portland, Ore., was not present when the photograph was taken.

More than 1500 administrators, chaplains and other hospital staff members sought new and better ways of extending the healing service of Christ through better patient care at the recent American Protestant Hospital Association meeting in Chicago. The first two days of the conference, the nine denominational groups and the Association of Protestant Hospital Chaplains directed their attention to general problems of hospital operation and those peculiar to the individual group's institutions.

Salvation Army representatives on Wednesday morning heard Sr. Maj. Ellen Dahlbom, superintendent of Boothe Memorial Hospital, Detroit, report a case study of how the mobility of population, physical plant improvements and group medical practice have affected the home and hospital services of her institution. In the analyzing area where her hospital is located, she noted that there had been a decided shift to an industrial type of community with younger families choosing the suburbs and the low income, foreign-born residents with little or no formal education remaining. Major Dahlbom stated that in the past five years there had been a 38 per cent decrease in private patient occupancy with no change in the high occupancy rate in the home for unwed mothers.

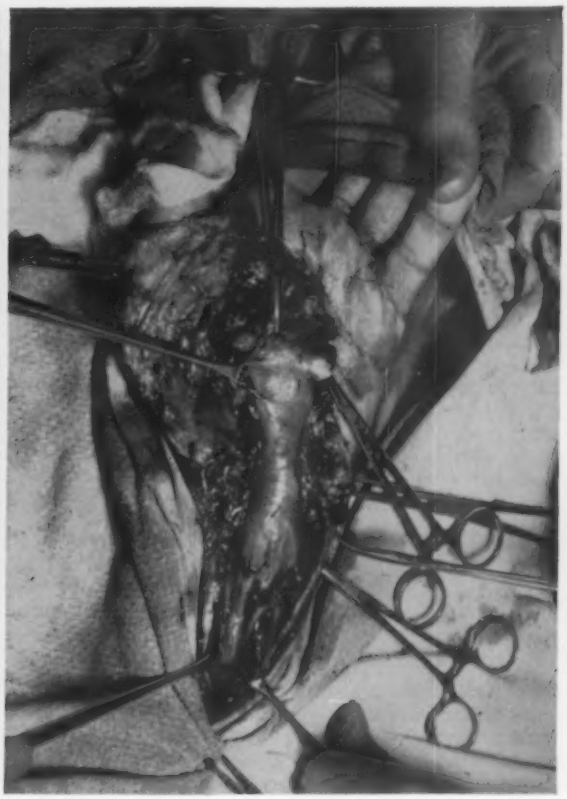
One of the controversial issues centered on the pros and cons of agencies, such as the Salvation Army, affiliating with a teaching hospital, which a group of doctors has built and where they have been appointed members of the medical staff.

At the Wednesday afternoon sectional meeting of the National Association of Methodist Hospitals and Homes, Dr. Frank R. Bradley, president of the American Hospital Association, recommended that administrators understand the psychological aspect of the consumer of hospital care before tackling the job of telling the hospital costs' story. Administrators must remember that the public is an involuntary purchaser of hospital and medical care. Secondly, no matter how effective the cost story is presented, we can not give the public really what they want—freedom from sickness and death. He suggested the general, good will type of hospital cost story that emphasizes the services of the institution, including the care of charity cases.

When telling the hospital story, Bruce W. Dickson Jr., administrator of Bethany Hospital, Kansas City, Kan., believes we should not apologize for hospital costs if we have critically analyzed the services the hospital provides and are convinced that they are the best.

The session closed with a discussion of the value of accounts receivable, methods of computing uncollectibles and use of outside collection agencies. Bolton Boone, administrator of Methodist Hospi-

Tumor of the left hand.



Resection of tumor.

Photographs: DAVID LUBIN, Medical Illustration Service, U. S. V. A. Hospital, Cleveland 30, Ohio

For pictures like these . . .

needle-sharp . . . color-true!

Price $72.50. Other Kodaslide Projectors from $23.95 to $246.
Prices include Federal Tax where applicable and are subject to change without notice.

Ask to see the

Kodaslide Signet 500 Projector

Your Kodak photo dealer has it.

Here are some of the features that make this unit a "must."

Powerful 500-watt lamp . . . for new color realism. *Sharp* f/3.5 lens . . . (f/2.8 available). *Instantaneous* slide changing . . . through top. *Automatic restacking* of slides after showing. *Power cooling* with impeller blower. *Rigid construction* . . . die-cast aluminum body. *Handy to use* . . . switch, slide-feed both operated from right side. Long cord. Individual elevating legs.

EASTMAN KODAK COMPANY, *Medical Division,* Rochester 4, N. Y.

Serving medical progress through Photography and Radiography

Kodak

tal, Dallas, Tex., reported on his hospital's successful experience in using limited liability notes with doctors in financing accounts.

At Wednesday evening's banquet, Dr. Theodore G. Klumpp, chairman of the Hoover Commission's Task Force on Medical Services, called for drastic overhauling in the present methods of caring for the aged and chronically ill. The gravity of the problem can not be overlooked, Dr. Klumpp stated, when one considers there are more than 13 million persons 65 years of age and over with an expected jump to 32 million by 1980. He also noted that there are approximately two and one-half million handicapped and 27 million chronically ill persons in the United States today.

Dr. Klumpp further remarked that the relegation of the care of these groups to federal, state or city governments is neither desirable nor practical. The work of such agencies, while vital, is necessarily too "impersonal" and should be supplemented by the "sympathy and compassion" of family, friends, churches and local communities.

At Thursday morning's meeting of the Southwide Baptist Hospital Association, Clyde L. Sibley, administrator of Birmingham (Ala.) Baptist Hospital, outlined some methods used at his hospital for getting visitors to observe regulations. Use of a theater rope across the entrances to the nursing areas has been a successful deterrent to before-10 a.m. visitors. He suggested enlisting the support of the local clergymen to sell their congregations on observance of hospital visiting hours. Booklets for patients explaining the whys and wherefores of the visiting hour regulations is an important tool in whipping the evils of overvisiting, Mr. Sibley remarked. At Baptist hospital, several of the cartoons from the patient book have been reproduced in color, mounted and placed in the lobby.

On Friday morning each of the denominational groups met in general session to take up the problem of the hospital's responsibilities in meeting the spiritual needs of the patient.

Two business sessions were also on the agenda for Friday morning. The Association of Protestant Hospital Chaplains referred the revised standards for chaplains to a committee of past presidents of the chaplains' group for further study with action to be taken at next year's convention. The group also approved a resolution of appreciation to the American Protestant Hospital Association for establishing a $10,000 fund to help chaplains who need financial assistance in completing their education.

In addition to the officers elected at the business meeting of the American Protestant Hospital Association (Photograph page 160), the following APHA trustees were elected: Dr. Karl S. Klicka, administrator, Presbyterian Hospital, Chicago; Elmer W. Paul, administrator, Methodist Hospital, Lubbock, Texas; Robert W. Bachmeyer, administrator, St. Barnabas Hospital, Minneapolis; Rev. A. H. Schmeuszer, D.D., administrator, Evangelical Deaconess Hospital, Milwaukee, and Rev. Carl R. Plack, director, chaplaincy service, Division of Welfare, National Lutheran Council, Washington, D.C.

AMA COUNCIL CLARIFIES—

Position of HIP Doctors on Advertising

The Judicial Council of the American Medical Association has ruled that the conduct of Dr. Ben E. Landess, a Queens County physician affiliated with a medical group of the Health Insurance Plan of Greater New York (HIP), does not violate the ethics of the American Medical Association dealing with solicitation of patients by advertising.

The Judicial Council, sometimes called "the supreme court" of medicine, clarified the ethical position of physicians associated with the Health Insurance Plan of Greater New York in regard to advertising.

In a test case, the Council's ruling involved Dr. Landess, medical director of the Jamaica Medical Group, affiliated with the Health Insurance Plan of Greater New York. In May 1954, the house of delegates of the Medical Society of the State of New York upheld the Queens County society whose board of censors found that Dr. Landess was guilty of unethical conduct under that portion of the Code of Professional Conduct dealing with unethical advertising.

The Council specifically stated it was not ruling on certain charges and countercharges, involving HIP operation and the action of the Queens County Medical Society.

It also pointed out that the AMA's Board of Trustees had authorized an exhaustive study of medical care plans which "will include a thorough analysis of the HIP type of organization among others."

The five-member Judicial Council ruled:

"Since on the record before us the Health Insurance Plan of Greater New York is organized and operates in accordance with law and may lawfully advertise; since the quality of its advertising is not an issue, and since Dr. Landess had nothing to do with the preparation or distribution of the advertising, it is our opinion contrary to that of the state and county medical societies that the conduct of Dr. Landess does not violate the ethic relating to solicitation and advertising."

Continuing, the Council said in its opinion:

"In view of the advisory nature of the county society's report and since Dr. Landess has not been deprived of any membership privileges, we believe our opinion disposes of this appeal and no further action by the Judicial Council is called for at this time."

The decision was rendered after months of study of the evidence by the Council whose members also heard oral arguments in the case during the AMA Clinical Session, held in Miami early last December.

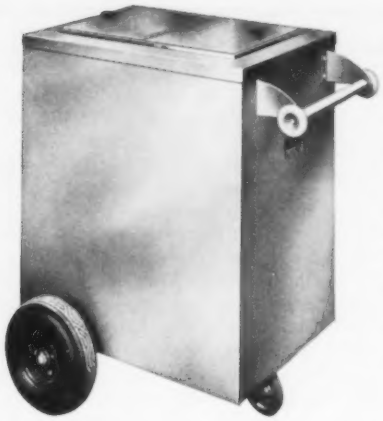
The judicial power of the American Medical Association is vested in the Judicial Council, whose decision, according to the AMA constitution and bylaws, is final.

In a release on the decision, the American Medical Association said:

"The Dr. Landess case was one of the most heated and controversial ever to come before the Judicial Council. Commenting on this fact in its issue of June 5, 1954, *New York Medicine* said:

" 'Tens upon tens of thousands of words have been written and published by the press and in medical magazines on the HIP type of closed-panel group practice of medicine, when such group practice is coupled with an insurance company that advertises for subscribers who then become the patients of a selected, monopolistic, small, closed-panel of doctors.' "

The case was based on the claim that Dr. Landess was unethical be-



SEMI-ENCLOSED TRUCK
MODEL TC 100
31½" x 23" x 51⅓" high
Designed primarily for use with bulk food conveyors to transport trays of complete meals from the diet-kitchen to the patient. Six meal capacity — even the last tray served will still be hot and appetizing. Tray guides have 7" spacing and will take 15¼" x 20½" trays. This truck may also be used to transport linen, cases of milk, soft drinks and other supplies. The truck is made of 302 stainless steel and is fully protected by IDEAL exclusive bumper. Requires a minimum of storage space.

ICE TRUCK
MODEL IT 150
36½" x 30½" x 40¼" high
This fully insulated ice truck is fabricated of 302 stainless steel throughout, and has a capacity of 150 pounds. Equipped with full size pneumatic wheels which provide ease of movement, and sturdy push handle with doughnut rubber bumpers for cart protection. The center hinged insulated cover provides easy access to ice.

UTILITY TABLE
MODEL MT 100
20" x 16" x 32" high
Solid stainless steel utility table with guard rail welded to body, and smooth running 3" casters. The full size drawer — 14½" x 13¼" x 3½" deep — operates on stainless steel slides equipped with ball bearings and drawer stops. An IDEAL table for use by anesthetist and as an all-purpose utility cart.

G-P TABLE
MODEL DT 100
33" x 18" x 29½" high with glides
The IDEAL general purpose table for instrument and dressing use, with general applications as a formula room table, tray delivery table, or linen carrier. Made of solid stainless steel throughout with ⅞" guard rail. Available with glides as shown above, or with smooth running 3" casters. 32½" high, with casters.

NEW IDEAL
time savers
for today's modern hospital

The Swartzbaugh Manufacturing Company, known for many years as the foremost producer of mobile food service equipment for the nation's hospitals, is now proud to announce a new line of IDEAL stainless steel products. Into these new products goes the same engineering know-how and the same high quality that have made the name "IDEAL" famous in hospitals the world over.

Write for full information

Ideal® HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Made only by the
SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

cause his name appeared in HIP advertising.

The Council's ruling said in part:

"The following appears to be the basis of the decision that Dr. Landess violated the ethic pertaining to advertising: The Queens County Medical Society found that the Health Insurance Plan of Greater New York advertised directly to the public and that by means of this advertising Dr. Landess 'directly benefits by the solicitation of patients . . . inasmuch as the HIP solicits patients only for the groups of physicians which are contractually bound to it.' . . .

"We do not mean to imply by our decision in this appeal that a physician can ethically associate himself with an organization which is either unlawful or one which indulges in improper or unethical advertising, nor absolve himself from appropriate disciplinary action by complacence or indifference . . .

"The parties at various stages of these proceedings interjected a variety of subjects, some of which we refer to briefly. In the memorandum filed for Dr. Landess the contention is made and vigorously argued that the county society has hampered and injured the Health Insurance Plan of Greater New York in violation of state and federal laws relating to conspiracy and restraints of competition. We do not render any decision on this contention. . .

"The printed and oral arguments also devoted considerable time to the character of the Jamaica Medical Group and its arrangements with the Health Insurance Plan of Greater New York. The county and state societies have argued that the arrangements between the Health Insurance Plan of Greater New York and the members of the HIP groups deny free choice of physician. Dr. Landess, on the other hand, contends that this arrangement assures free choice of physician. . .

"It is clear that neither the report of the county society nor the evidence adduced by the parties are adequate for us to make a thorough analysis in this case. Decision on matters of this nature would obviously have an impact on physicians involved in numerous arrangements of which we may not now be aware."

AHA CONVENTION HOST

Atlantic City . . . City of Hotels

The city of hotels—that is Atlantic City. And well it should be, for it is a city for conventioners and vacationers; hotels and amusement its principal industries.

It is here that hospital administrators and key personnel will gather next fall for the fifty-seventh annual convention of the American Hospital Association, September 19 to 22. Hotel reservation blanks will be mailed from Chicago headquarters this month.

This little city of approximately 60,000 permanent residents offers its visitors 27,000 hotel rooms and an estimated 12,000 additional rooms in rooming houses and tourist cottages. Seventeen beachfront hotels tower above the Boardwalk, giving the town a waterfront skyline that could be that of a metropolitan community. The majority of the other hotels are within one block of the beach.

No two of the hotels are alike. One may feature huge domes, which remind one of a castle in *Arabian Nights*. Another may stand out by virtue of its minarets. A third may give prominence to a court of colorful flower beds or an outdoor pool and cabana club. Others follow the more simple lines of modern architecture.

Largest of the hotels is Chalfonte-Haddon Hall, with 1,000 sleeping rooms. Tallest is the 18-story Claridge.

The centrally located Traymore Hotel, with its variety and flexibility of meeting rooms, will be the headquarters of the American Hospital Association. Here the House of Delegates and the Board of Trustees will meet.

The American College of Hospital Administrators also will headquarter in the Traymore. Headquarters for Hospital Auxiliaries will be the Marlborough-Blenheim. Also in the vicinity of Convention Hall are the headquarters hotels of other groups that hold their annual meetings in conjunction with the Association: American Association of Nurse Anesthetists, Ritz-Carlton; American Association of Hospital Consultants, Claridge, and Association of Hospital Planning Agencies, Dennis.

The hotel reservation form should be completed and returned to the AHA Housing Bureau at the Convention Bureau in Atlantic City as quickly as possible.

Proposed Bill Opens Hospital Staffs to Any Licensed Doctor

A bill which throws open the doors of hospital staffs to any licensed physician in the state has been introduced in the Indiana legislature with strong backing of the American Legion.

The bill carries out a resolution passed at the 1954 convention of the American Legion, urging state legions to take such action. Legion strength is especially great in Indiana, AL national headquarters.

The measure requires that facilities of public supported hospitals (excepting federal hospitals) and hospitals getting any public funds and hospitals getting any tax exemptions be made available to any graduate of any recognized medical school who has an unlimited license to practice medicine in Indiana.

Privileges, which must be granted, include basic medicine, pediatrics, certain obstetrical procedures and certain surgical procedures.

The Indiana Hospital Association and the Indiana Medical Association have lined up in firm opposition to the proposal. One hospital official pointed out that the bill takes away all staff appointment control from the board of trustees, which is still legally responsible and liable. He predicted that similar situations may face other states.

It is hoped to prevent the bill from emerging from the public health committee of the legislature.

AHA State Advisory Counselors Named from 39 States

The appointment of eight additional state advisory counselors for the American Hospital Association hospital auxiliaries program has been announced since the list of new advisory counselors was published in the December 1954 issue of HOSPITALS. To date, advisory counselors have been named from 39 states.

Additions to the advisory counselor roster include: Georgia, Mrs. Russell Bellman (St. Joseph's Infirmary Auxiliary), 2804 Andrews Dr. N.W., Atlanta; Missouri, Mrs. Hugh Morton (St. John's Hospital Auxiliary), 819 Kingsbury, Springfield; Nebraska, Mrs. C. E. Klindt, (Auxiliary of Immanuel Deaconess Institute), 3019 Titus St., Omaha; New Hampshire, Mrs. Laurence I. Duncan (Concord Hospital Auxiliary), 103 Centre St., Concord; North Dakota, Mrs. Palmer Rustan (Women's Auxiliary of Good Samaritan Hospital), 518 Third Ave.

PYROGEN-FREE DISTILLED WATER FOR EVERY NEED

...at VASSAR HOSPITAL with BARNSTEAD STILLS and Tank Combinations

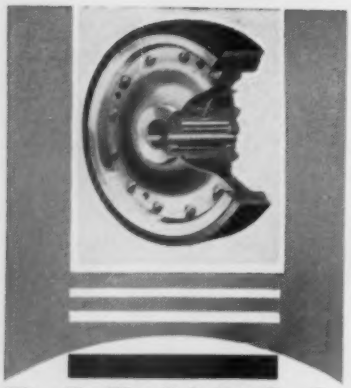
In the Central Supply Room at Vassar Hospital, Poughkeepsie, New York, two Barnstead Stills are teamed with Barnstead Pyrex Tanks to provide pure, pyrogen-free water for every need . . . and for years to come.

Hospitals throughout the world rely on Barnstead — since 1878 the *first* name in pure water — to meet today's increased demands for distilled water in Central Supply, Pharmacy, and Laboratory. Compact, economical to operate, easy to clean, Barnstead Still and Tank Combinations produce water of highest purity *quickly* — store it *safely* for immediate or future use.

Over 200 Different Styles and Sizes including Full Automatic Controls, Distilled Water Purity Regulators etc.

Barnstead
STILL & STERILIZER CO.

27 Lanesville Terrace, Forest Hills, Boston 31, Mass.

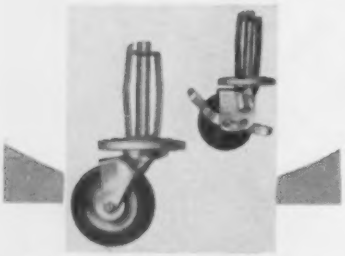


DARNELL

Always SWIVEL and ROLL

CASTERS & WHEELS

1. LONGER EQUIPMENT LIFE
2. GREATER FLOOR PROTECTION
3. EASY EQUIPMENT MOVABILITY



These casters are doing a great job for many of the country's largest hospitals. Models shown here are especially made for beds, examination tables and other hospital equipment. Also available with special stems, plate tops, angle fittings, etc. They offer ease of movement, quietness, floor protection.

The Darnell treads, whether of soft, resilient, semi-resilient rubber, or tough, hard synthetic composition, give long life and are guaranteed against elongation.

Free Manual

DARNELL CORPORATION, LTD
DOWNEY (LOS ANGELES COUNTY) CALIFORNIA
60 WALKER STREET, NEW YORK 13, NEW YORK
36 NORTH CLINTON STREET, CHICAGO 6, ILLINOIS

E., Williston; Ohio, Mrs. Sinton P. Hall (The Co-operative Society, Children's Hospital), 2640 Briarcliffe, Cincinnati; Oklahoma, Mrs. Vern James (Women's Auxiliary of Norman Hospitals), 168 Morningside Dr., Norman, and Virginia, Sue H. Brooke (Women's Auxiliary of Norfolk General Hospital), 221 52nd St., Virginia Beach.

New England Hospital Assembly To Meet in Boston, March 28-30

Boston will be host late this month to more than 5,000 hospital administrators, doctors, nurses, trustees, technicians, women's auxiliary members and other hospital personnel for the 32nd annual meeting of the New England Hospital Assembly. Planned by New England hospital leaders in a series of ten program committee meetings during the past year, the New England Hospital Assembly will be held at the Statler Hotel, March 28-30.

Program Chairman Richard T. Viguers, administrator of New England Center Hospital, Boston, has announced that the three-day program will include 20 sessions dealing with all phases of hospital work.

This year, for the first time, 27 instructional conferences are being offered to hospital staff members in addition to the regular program.

Group Adopts in Principle Uniform Medical Practice Act

The recommendations of a committee appointed to draft a uniform medical practice act that could be used as a guide or model by state medical boards in future revisions of their medical practice acts were adopted in principle in Chicago last month. The action was taken by the Federation of State Medical Boards of the United States during the fifty-first annual Congress on Medical Education and Licensure.

The committee was continued with authorization to appoint such subcommittees necessary to define the Federation's ultimate objectives and area of interest in a uniform medical practice act.

The recommendations of the committee, presented during the meeting and discussed by a panel, were limited to those phases of licensure that are of the greatest importance in achieving as nearly as possible universal reciprocity and/or endorsement between the states.

Points covered in the recommendations were the definition of the practice of medicine, licensure standards, examinations, reciprocity and endorsement, and grounds for probation, suspension and revocation of license.

Any uniform act which the Federation of State Medical Boards may adopt will be only a recommendation and will not be obligatory upon any state.

The draft defines the practice of medicine as "the diagnosis, treatment or correction of, or the attempt to, or the holding of oneself out as being able to diagnose, treat or correct, any and all human conditions, ailments, diseases, injuries or infirmities, whether physical or medical, by any means, methods, devices or instrumentalities."

Pointed out is the fact that dentistry, nursing and all other healing arts, given legal status in the various states, may be specifically exempted from the definition, but all persons engaged in any activity covered by the definition and not specifically exempted would be subject to prosecution for practicing medicine without a license.

One of the requirements for eligibility for licensure is the candidate must have satisfactorily completed one year of internship in a hospital approved by the board. A rotating internship is not specified.

One ground for probation, suspension and revocation of license is "employing as a practitioner of medicine, in the practice of his profession, any person not duly licensed, or otherwise aiding, assisting or abetting the unlawful practice of medicine or any other healing art."

Hospitals Seek Court Decision on Dispute with Specialists

The Iowa Hospital Association and 28 individual Iowa hospitals have formally asked the courts to settle their dispute with certain specialists.

The then Attorney General of Iowa, who was since elected Governor, ruled last year that the hospital practice of billing for pathological and laboratory services violated the state's medical practices act as it related to the corporate practice of medicine.

In a suit filed January 31, the hospitals asked the court for a declaratory judgment stating that:

"Ownership, operation and maintenance of laboratory facilities are an integral part of the lawful operation of a hospital and that

Let's tell everybody..

about
OUR "CASE"
FOR MARCH
AND APRIL

1,000 FREE FLEX-STRAWS

(two boxes) in every case purchased..!

YOU ORDER 10,000 (ONE CASE)
YOU PAY FOR 9,000 AT THE LOWER CASE LOT PRICE.

USE FLEX-STRAWS EXCLUSIVELY IN ALL WARDS

- SAFE
- SANITARY
- DISPOSABLE

Hospital surveys prove Flex-Straws pay for themselves by eliminating drinking-tube upkeep—no sterilizing... collecting...re-issuing...breakage or replacement cost.

INITIAL COST...THE ONLY COST

LIST PRICES TO HOSPITALS

REGULAR (UNWRAPPED)		INDIVIDUALLY WRAPPED	
1M	$5.00 per M	1M	6.00 " "
5M	4.75 " "	5M	5.70 " "
10M (1 case)	4.50 " "	10M (1 case)	5.40 " "
4 cases or over	3.95 " "	4 cases or over	4.75 " "

ORDER FROM YOUR DISTRIBUTOR NOW...OFFER EXPIRES APRIL 30.

FLEX-STRAW COMPANY, 2040 BROADWAY, SANTA MONICA, CALIFORNIA

hospitals may charge and bill for services therein

"The governing board of a nonprofit, charitable hospital has a lawful duty and responsibility for the operation and maintenance of laboratory facilities

"Nonprofit, charitable hospitals have the right to employ pathologists as heads of or in connection with their laboratory facilities upon the same terms and conditions as they are now and always have been employed."

Defendants named by the hospitals were the Iowa State Board of Medical Examiners, the Iowa Association of Pathologists and the Attorney General of Iowa.

The hospitals charged "that certain of the defendants, and in particular, the president and secretary of the Iowa Association of Pathologists and the president and secretary of the State Board of Medical Examiners, are attempting to take away from the 170, charitable, nonprofit hospitals in the State of Iowa the right to charge for the laboratory services the law requires (the) hospitals to furnish and to place the right to charge for (the) services in the control of the members of (the) Iowa Association of Pathologists."

The plaintiff hospitals, representing all sizes and types of ownership of nonprofit hospitals in Iowa, complained in the suit that certain of the defendants sought to force hospitals to turn over to "said medical specialists the control of an integral part of their facilities which represents millions of dollars in buildings and equipment which have been entrusted by the public to the unpaid governing boards" of the hospitals.

The hospitals alleged that if the right of the nonprofit hospitals to perform and charge for laboratory services were turned over to the defendant specialists, "the Blue Cross . . . and the hospital insurance of many other insurance companies will be nullified and more than a million citizens of Iowa will suffer the loss of a substantial portion of their present hospital insurance."

The hospitals' suit said the Attorney General's opinion did not take into consideration the fact that the laws of Iowa relating to the licensure of hospitals required hospitals to provide the very services over which he drew a legal cloud. The court was asked to settle this alleged conflict.

The court was also asked to enjoin the defendants from interfering with the present method of operating hospital laboratories.

Before the Iowa hospitals took the controversy to court, the issue had been taken to the Iowa legislature.

A bill was introduced to add a new regulation to Iowa law concerning the acceptance of Hill-Burton funds for construction of a hospital or related facility. The new regulation, if enacted, would forbid the employment of physicians or dentists on a salary in a Hill-Burton hospital or facility, except for the medical and dental treatment of indigent patients by "the state of Iowa or subdivision thereof."

If the new regulation were enacted, every new applicant for Hill-Burton funds must agree "that each and every patient shall have free choice of his own physician or dentist."

The bill also provided that if, within 20 years after completion of construction, a Hill-Burton hospital or facility began employing physicians or dentists on a salary, the state of Iowa would be entitled to recover the full amount of the federal contribution and return it to the United States Treasury.

CONFERENCE PINPOINTS ROLES—

National Groups Pioneer; States Implement

At the Midyear Conference of Presidents and Secretaries of national, regional, provincial, state and metropolitan hospital associations in Chicago on February 4 an 5, 183 delegates carried out the theme, "Working Together for Better Patient Care."

Each of the nine topics discussed in the general sessions was presented first in terms of national policies and activities, and then in relation to programs underway at state and regional levels.

In the opening discussion of hospital-physician relationships, it was noted that the 1953 joint resolution of the American Hospital and Medical Associations established the fact that arrangements between hospitals and physicians were accepted in principle, but definitive details could be formulated only at the local level. Today the legal problems involved follow a general pattern, but are individual for each state. Recent rulings by the Attorney General of Iowa, and the supreme court of Michigan, are being opposed in court channels, according to reports from the hospital association in each of these states. From Massachusetts came a report on how problems of hospital-physician relationships are being met through joint action by the state hospital and medical associations.

Hospital-nursing relationships were next on the agenda. At the national level the emphasis was on nursing education: the development of the training program for nurse aides; the experimental two-year professional nursing course now being given in six junior colleges, and the problems of meeting accreditation requirements for the 623 schools of nursing whose temporary accreditation will end in June 1957.

At the luncheon program following the first morning session, Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, explained how the JCAH surveyor can appraise the quality of hospital care by inspecting the case histories behind ten routine hospital statistical ratios.

The afternoon program was devoted to legislation, small hospitals and institutes. The functions of the AHA Council on Government Relations—liaison, analysis and reporting, and legislative activity—were explained. The report from Washington noted some 4,000 bills now before Congress; but California produced a still larger statistic —5,700 bills before the California legislature. Reports from Connecticut and Pennsylvania pointed out that the hospital trustee, often himself a lawyer, can play an important role in legislative problems such as welfare reimbursement.

The discussion of small hospitals stressed the needs of these hospitals in utilization of new services and promotion of public relations. Nebraska and Mississippi reported programs geared to these hospitals. The institute program also provides an important service to this group. Here the national role is to develop, experiment and pioneer topics and technics; the state carries out and adapts to meet local needs. For example, Minnesota reported that its traveling institutes are reaching paramedical personnel who would never have attended a regular institute.

The final session of the conference began with a discussion of

TAMBLYN AND BROWN, Inc.

For 35 Years Public Relations-
Fund Raising Counsel
to America's Most Distinguished Hospitals,
Health and Welfare Agencies
and Educational Institutions.

Since 1920 Tamblyn and Brown, Inc., a Charter Member of the American Association of Fund Raising Counsel, has helped hospitals and other non-profit institutions and agencies meet situations that were *different*. Our experience in meeting the fund raising and publicity needs of nearly 1000 clients enables us to cope with new and unusual problems.

A permanent and diversely experienced staff is equipped to deal with conditions which require special techniques and unusual approaches, rather than a stereotyped plan of action.

If your hospital situation is different, an executive of Tamblyn and Brown, Inc. will gladly consult with your officers in confidence and without obligation on your part.

TAMBLYN AND BROWN, INC.

6 East Forty-Fifth Street **New York 17, New York**

uniform accounting, led by a report on the prospective manuals on cost accounting and small hospital accounting. Oklahoma reported the development of a uniform cost accounting program, and a report from Manitoba explained the "report accounting" system installed as a central service.

Blue Cross discussion focused on enrollment and control of utilization. Uniform benefits were stressed as essential to continued progress. Voluntary controls, developed through close liaison among hospitals, Blue Cross and the medical profession, were seen as the solution to utilization problems.

The topic of insurance brought a report on the forthcoming insurance manual. State reports emphasized the great saving and improved protection when hospitals act together through their state associations for insurance programs. California estimates that its liability insurance program has saved half a million dollars for the 88 participating hospitals.

The ladies had the last word in the general session, reporting on the auxiliary program. Reports from Connecticut and from Iowa stressed the public relations potential of the million members of the 1,049 AHA auxiliaries.

At the luncheon meeting, which closed the conference, AHA President-elect Ray E. Brown defined the purpose of hospital associations —to act collectively to accomplish what cannot be done by the individual hospital acting alone. This outlines the limits of national, state and regional activities. "The American Hospital Association must pioneer," said Mr. Brown, "so that the state association can implement."

South Carolina Hospital Group Elects New Officers

Richard G. Roach, administrator of the Orangeburg (S. C.) Regional Hospital, was chosen president-elect of the South Carolina Hospital Association at the group's annual meeting in Charleston, January 21. P. A. Hodges, assistant superintendent of the Columbia (S. C.) Hospital, was reëlected secretary-treasurer.

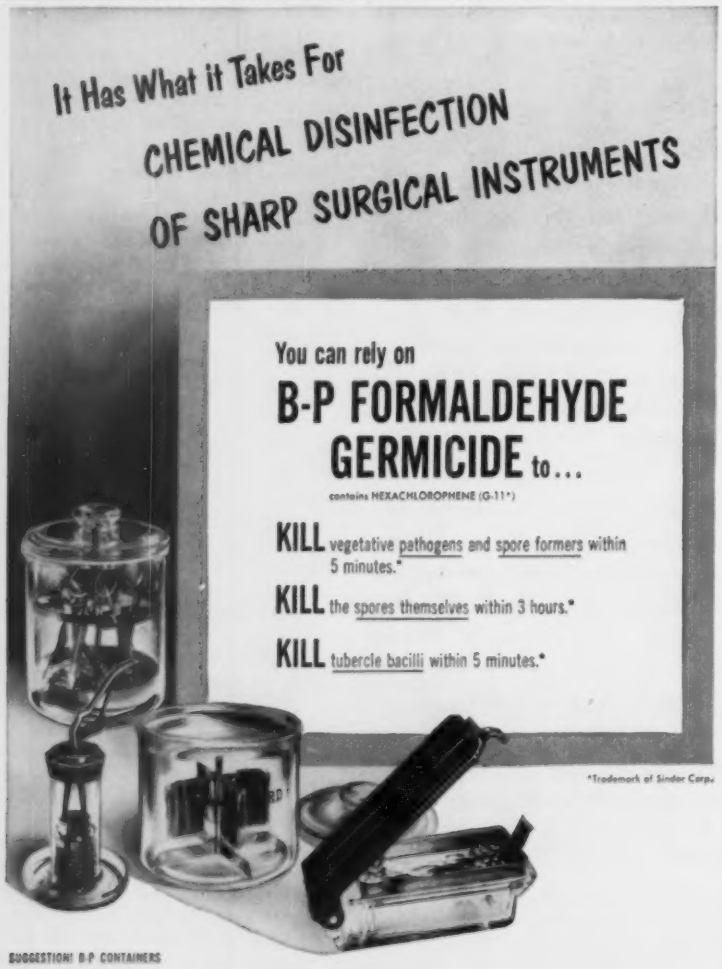
At the Carolinas-Virginias Hospital Conference next month, R. Mark Stanton, superintendent of McLeod Infirmary, Florence, will assume the office of president of the South Carolina Hospital Association, succeeding C. A. Robb, superintendent of Roper Hospital, Charleston.

Extension of General Hospital Recommended for Chronically Ill

Because of the current intensification of activities in the expansion of chronic disease facilities, the Commission on Chronic Illness has released certain of its specific conclusions in advance of its forthcoming report.

According to the Commission, "most longterm patients can best be cared for at home during much of their illness." The Commission, however, believes that home care programs organized to provide auxiliary services to the private physician offer the most effective method yet devised for bringing to longterm patients and their families the coördinated services required.

If the longterm patient cannot be satisfactorily treated in his own home, he should be transferred to an institution. A wide range of institutional services is needed. In regard to hospitals, the Commission's specific recommendations were as follows:


It Has What it Takes For
CHEMICAL DISINFECTION
OF SHARP SURGICAL INSTRUMENTS
You can rely on
B-P FORMALDEHYDE GERMICIDE to...
contains HEXACHLOROPHENE (G-11*)
KILL vegetative pathogens and spore formers within 5 minutes.*
KILL the spores themselves within 3 hours.*
KILL tubercle bacilli within 5 minutes.*
*Trademark of Sindar Corp.
SUGGESTION! B-P CONTAINERS are all especially designed for convenience in conjunction with the use of B-P GERMICIDE.
Used as directed, it will not injure keen cutting edges, points of hypodermic and suture needles, scissors and other 'sharps' . . . nor rust, corrode or otherwise damage metallic instruments.
IT'S THE ECONOMICAL ANSWER towards keeping annual costs for solutions and instrument replacement and repairs at a minimum. May be used repeatedly if kept undiluted and free of foreign matter.
*Comparative chart sent on request
Ask your dealer
PARKER, WHITE & HEYL, INC.
Danbury, Connecticut, U.S.A.

"DUET" SYRINGE BAGS GIVE YOU INCREASED STERILIZATION PROTECTION

REDUCE BREAKAGE

SPEED-UP WRAPPING

Barrel and Plunger separated in single container for complete safety!

Two compartments protect hypodermic syringes against breakage, insure a continuous aseptic sterilization technique. Made of wet strength paper with waterproof seams.

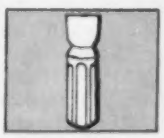
Two sizes–2 & 5 cc, and 10 cc, packed in handy dispenser cartons of 500.

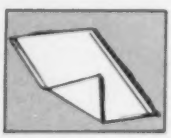
PRO-TEX-MOR HOSPITAL DIVISION

CENTRAL STATES PAPER & BAG CO.

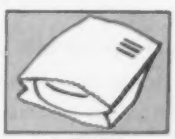
5221 NATURAL BRIDGE ST. LOUIS 15, MO.

Other PRO-TEX-MOR items for Hospitals


NIPPLE COVERS


DISPOSABLE BED PADS

BEDSIDE WASTE DISPOSER


FLUSHABLE BED PAN COVERS

VINYL PLASTIC PILLOW & MATTRESS COVERS

DISPOSABLE LINERS FOR STEP-ON WASTE RECEPTACLES

EXAMINATION CAPE

EXAMINATION TABLE SHEETING

ORDER PRO-TEX-MOR HOSPITAL PRODUCTS FROM THESE FIRMS!

ARKANSAS
LITTLE ROCK
Wm. T. Stevor, Inc.

CALIFORNIA
FRESNO
Bischoff's
LOS ANGELES
Western Surgical Supply Co.
OAKLAND
Bischoff's
SAN FRANCISCO
Western Surgical Supply Co.

COLORADO
DENVER
Denver Surgical Supply Co.
Durbin Surgical Supply Co.

CONNECTICUT
BRIDGEPORT
American Surg. Supply & Equip.
HARTFORD
D. G. Stoughton Co.

IDAHO
BOISE
Intermountain Surgical Supply Co.

ILLINOIS
CHICAGO
The Burrows Company
Colonial Hospital Supply Co.
Hospital Equipment Corporation
Mills Hospital Supply
EVANSTON
Suburban Surgical Supply Inc.
FOREST PARK
Harris Hospital Supply Co.

INDIANA
FORT WAYNE
Wayne Pharmacal Supply Co.
HAMMOND
Physicians Supply Co.
INDIANAPOLIS
Curtis & French, Inc.

IOWA
DUBUQUE
Holscher's Physician & Hospital Supply

KANSAS
TOPEKA
Munns Medical Supply Co.
WICHITA
Midwest Surgical Supply Co.

KENTUCKY
LOUISVILLE
Theodore Tafel

LOUISIANA
NEW ORLEANS
Surgical Supply Company, Inc.

MAINE
PORTLAND
George C. Frye Co.

MASSACHUSETTS
BOSTON
W. J. Fitzgerald Corp.
Thomas W. Reed Co.
Surgeons & Physicians Supply Co.
WORCESTER
A. E. Thompson Inc.

MICHIGAN
FERNDALE
The J. F. Hartz Co.

MINNESOTA
MINNEAPOLIS
Physicians & Hospitals Supply Co.
ST. PAUL
Brown & Day, Inc.

MISSOURI
JOPLIN
Goetze-Niemer Co.
ST. LOUIS
C. W. Alban Company
Hamilton Schmidt Surgical Co.
Chas. A. Schmidt Inst. Co.

NEVADA
RENO
Reno Rents

NEW JERSEY
EAST ORANGE
Hospital Equipment Corporation
HACKENSACK
Cosmeva Surgical Supply Co.
ORANGE
Garrett Byrnes & Son

NEW YORK
BUFFALO
John L. Landis & Co.
Charles P. Mugler & Co.
NEW YORK
Institutional Products Corp.
ROCHESTER
Physician's Supply Corp.
WHITE PLAINS
G & D Surgical & Drug Co. Inc.

OHIO
CANTON
Bowman Bros. Drug Co.
CLEVELAND
Schuemann-Jones Co.
COLUMBUS
Wendt-Bristol Co.
DAYTON
Fidelity Medical Supply Co.
MANSFIELD
Caldwell & Bloor Co.

PENNSYLVANIA
HARRISBURG
Capitol Surgical Supply Co.
JOHNSTOWN
Johnstown Physicians Supply Co.
PITTSBURGH
Feick Brothers Co.

RHODE ISLAND
PROVIDENCE
The Claflin Company

TENNESSEE
MEMPHIS
Delta Surgical, Inc.
Kay Surgical Inc.
Richards Mfg. Co.
NASHVILLE
Massey Surgical Supply, Inc.
Theodore Tafel

TEXAS
DALLAS
E. H. McClure Co.
Stanley Supply Co. Inc.
FORT WORTH
Terrell Supply Co.
HOUSTON
W. A. Kyle Company
SAN ANTONIO
Noa Spears Company

UTAH
SALT LAKE CITY
Physicians Supply Co.

VIRGINIA
RICHMOND
Southern Medical Supply Co.

WASHINGTON
SEATTLE
Shaw Supply Co. Inc.
Shipman Surgical Co.

CANADA
MONTREAL, P. Q.
Millet, Roux & Cie, Limitee
WINNIPEG, MAN.
Hyman Surgical Supply, Ltd.

PUERTO RICO
SANTURCE
United Medical Equipment Corp.

HAWAII
HONOLULU
McKesson & Robbins Inc.

1. The *most desirable* approach to providing hospital care to longterm patients is through extension, organization and coördination of the facilities and services of general hospitals both private and public. In some general hospitals this will require only an extension of the hospital's responsibility and reorientation of the staff so that diagnostic and therapeutic services—disproportionately dedicated to acute illness—will be appropriately and adequately applied to the chronically ill. In many other hospitals additional beds will be needed and personnel, space and equipment required to provide specialized services to the longterm patient. In all general hospitals the concept, philosophy and practice of rehabilitation must be paramount.
   a. *Short-term care of the chronically ill in a general hospital.* All general hospitals should devote an appropriate share of their services to longterm patients. The general hospital — of whatever size — which cannot accept responsibility for both short-term and longterm care, should extend to the patient with a chronic disease these services which are likely to be short-term: services for diagnosis and treatment of intercurrent acute illness; evaluation of the need for services not provided by the general hospital, or better or more economically provided in other types of institutions; and the development of a plan for continued care. The trend of extending psychiatric services in general hospitals, for treatment as well as diagnosis, should be encouraged.
   b. *Longterm care in a general hospital.* General hospitals should provide adequate units and services for patients requiring prolonged periods of care.

      The large general hospital is urged to equip itself with the full range of facilities, both for the patients needing skilled nursing service and rehabilitation, and units for those needing less skilled care. A chronic disease unit offering primarily skilled nursing service and physical medicine is recommended for the large general hospitals.

      The small general hospital that cannot provide, through its own resources, the full scale of services is urged to make arrangements on a regional basis for services to be available at the small hospital.
2. The *independent* chronic disease hospital is a second choice approach to longterm hospitai care. It should be considered only when there is no practical way to associate the chronic disease facility physically and administratively with the general hospital. Where a special chronic disease hospital is unable to affiliate itself with a general hospital, it must have adequate facilities and personnel for thorough diagnostic work-up, intensive study of the patient and a dynamic program for definitive medical care and rehabilitation. The construction of new independent chronic disease hospitals (except research institutions) is not recommended.
3. Progress in control of a number of the more serious chronic diseases depends upon research which can be conducted best where substantial numbers of patients can be observed over a

Now! This gleaming, easy-to-clean VOLLRATH stainless steel Bedside Set

3-pc. Bedside Set includes:
No. 6841 — Water Bottle, 1 qt. cap.
No. 6847 — Tumbler, 7 oz. cap.
No. 8110 — Tray, 10¼ x 6¾ x ½ in.

Designed for today's standards . . . built for everlasting service!

Good looks and good service go hand in hand with this wonderful Vollrath stainless steel Bedside Set. Its gleaming finish lasts through the years . . . the sturdy steel takes the bumps in stride. And nothing is easier to keep sterile than stainless steel! Write us for complete information today.

First in STEEL Utensils
Stainless Steel and
Porcelain Enameled Steel

SINCE 1874
The Vollrath Co.
SHEBOYGAN WISCONSIN

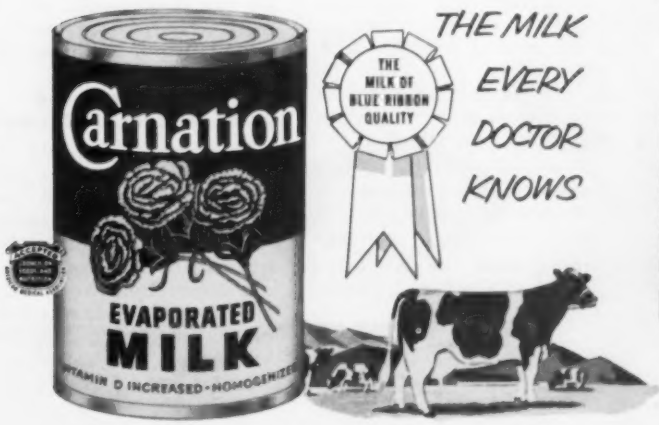
How Carnation protects the baby's formula from farm to bottle

Guards Your House Formula Five Important Ways

(1) Here, at the famous Carnation Farms near Seattle, Carnation's vigilance begins.

Cattle from the world-champion Carnation bloodlines are shipped to Carnation supplier herds throughout America.

Thus, daughters of such famous champions as Carnation Ormsby Madcap Fayne and Carnation Homestead Daisy Madcap help in improving the milk supply of Carnation plants.



(2) Carnation supplier dairy herds and farm equipment are inspected regularly by Carnation Field Service Men. Only milk meeting Carnation's high standards is accepted.

(3) In the Carnation Laboratories, continuing research guards the purity and the nutritive values of Carnation Milk—develops new and improved processing methods.

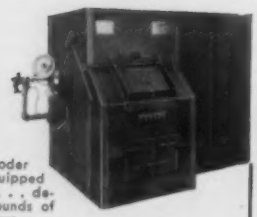
(4) Every drop of Carnation Milk is processed solely by Carnation, in Carnation's own plants, to Carnation's high standards, assuring constant high quality, uniformity.

(5) Carnation store stocks are date coded and inspected regularly by Carnation salesmen to assure freshness and high quality whenever a mother makes her purchase.

when you plan

to:
SAVE COSTS
SAVE TIME
SAVE SPACE

insist on . . .
JOSEPH GODER INCINERATORS



The Joseph Goder 2450-IRN equipped with burner . . . destroys 500 pounds of refuse per hour.

Now is the time to equip your hospital with the most modern way to dispose of rubbish, garbage and pathological waste . . . a Joseph Goder Incinerator! Its efficient and sanitary operation makes it the favorite of hospitals and sanitariums everywhere. All but smokeless in operation.

Whatever your need . . . small prefabricated incinerators . . . or a large custom-built installation . . . you can depend on Joseph Goder to do the job BETTER!

Typical of a Joseph Goder hospital installation is found at Rockford Memorial Hospital, Rockford, Illinois, where a 220-N Incinerator was installed. Architects—Perkins & Will, Chicago, and Hubbard & Hyland, Rockford. Contractor—Security Building Company, Rockford.

INCINERATORS Joseph Goder NO ODOR WRITE TODAY FOR INFORMATION!

Joseph Goder Incinerators
5121 N. Ravenswood Ave.—Chicago, Illinois
Please send complete information on Joseph Goder Incinerators and your *Incinerator Blue Book*
Name .....
Hospital .....
Address .....
City .....Zone .....State .....

long period of time. Chronic disease hospitals and chronic disease units of general hospitals have a unique opportunity to conduct such investigations and should include research among their principal functions.

4. The longterm patient belongs in private general hospitals as well as in tax-supported general hospitals—a combination of voluntary and public effort is applicable to the care of the longterm patient as it is to the care of the acutely ill patient.

The Commission notes that for many mental patients the general hospital offering psychiatric services represents the appropriate source of care. Nursing homes and related institutions are essential for some phases of longterm illness. The Commission believes that development of these institutions as elements of general hospitals is one of the best ways of raising standards, and recommends this arrangement. When outright affiliation is impossible, a close and active working relationship should be maintained.

Seeks to Levy Service Charge Against Nontaxable Agencies

The Works Board of Indianapolis has voted to ask the Indiana legislature for permission to levy a service charge against nontaxable agencies, making such units pay for street, sidewalks, sewer and lighting improvements. The Indiana Hospital Association and other government and charitable institutions in the state have made it known that they will endeavor to defeat such legislation if it is proposed because:

1. Such legislation would defeat the purpose of tax exemption.

2. In the case of hospitals, such legislation would only limit the services that the hospital provides or increase costs at a time when the patient can least afford it.

Reaffirms voluntary method
(Continued from page 157)

construction under the new categories added in the last Congress.

NURSE TRAINING AID

The Administration proposed that the Surgeon General be authorized to establish traineeships for:

Professional nurses qualified for teaching positions and for administrative or supervisory functions.

Professional public health personnel, including public health nurses.

Among the benefits of such a program, the Administration said would be elevation of the quality of nurse education, improvement in hospital and health agency administration, and prevention of waste of nurses' time and skills.

A five-year grant program for the training of practical nurses was proposed. The states would provide 25 per cent of the funds for the first and second years and 50 per cent thereafter. The grants would be for instruction and administration of the training programs.

The legislation is needed, it was argued, "to partially relieve hospitals of their responsibility for training nursing aides" and because "more practical nurses are needed."

PUBLIC ASSISTANCE GRANTS

The Eisenhower Administration proposed to provide dollar-for-dollar matching grants to the states for the medical care of certain public assistance recipients. It would give up to $3 per month extra for adults and up to $1.50 per month for children in the following four categories: aid to the blind, aid to dependent children, the permanently and totally disabled, and for old age assistance.

MENTAL HEALTH

The Administration proposed to extend its categorical grants-in-aid to states for mental health programs (while consolidating other grants to permit more flexibility of use) and also proposed to authorize special project grants for the development of improved methods of care, treatment and rehabilitation of the mentally ill.

Health Bills Introduced Already Reached All-time High

The number of health bills already introduced in the 84th Congress has reached an all-time high.

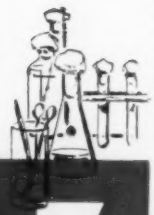
Bills have been introduced to cover most phases of the Administration's health program.

Individual members of Congress have dropped their own pet health proposals into the legislative bin. In addition, the forthcoming reports of the Hoover Commission and the Commission on Intergovernmental Relations should bring another spate of health proposals.

VA Construction Program. A number of the health bills would authorize

a size for every hospital need

From ENT clinic to the OB ward . . .
all departments find CAROLAB COTTON BALLS
are handy and convenient to use—
completely free of nibs and wispy ends.
They are also an economical substitute
for sponges in many hospital procedures.
The laboratory and dispensary
find that they save time and money.
Cleaning instruments and equipment,
stopping test tubes, bottles and capsule containers,
are all duties which can be speeded up
at lower costs with CAROLAB.



7 reasons why leading hospitals choose CAROLINA COTTON BALLS

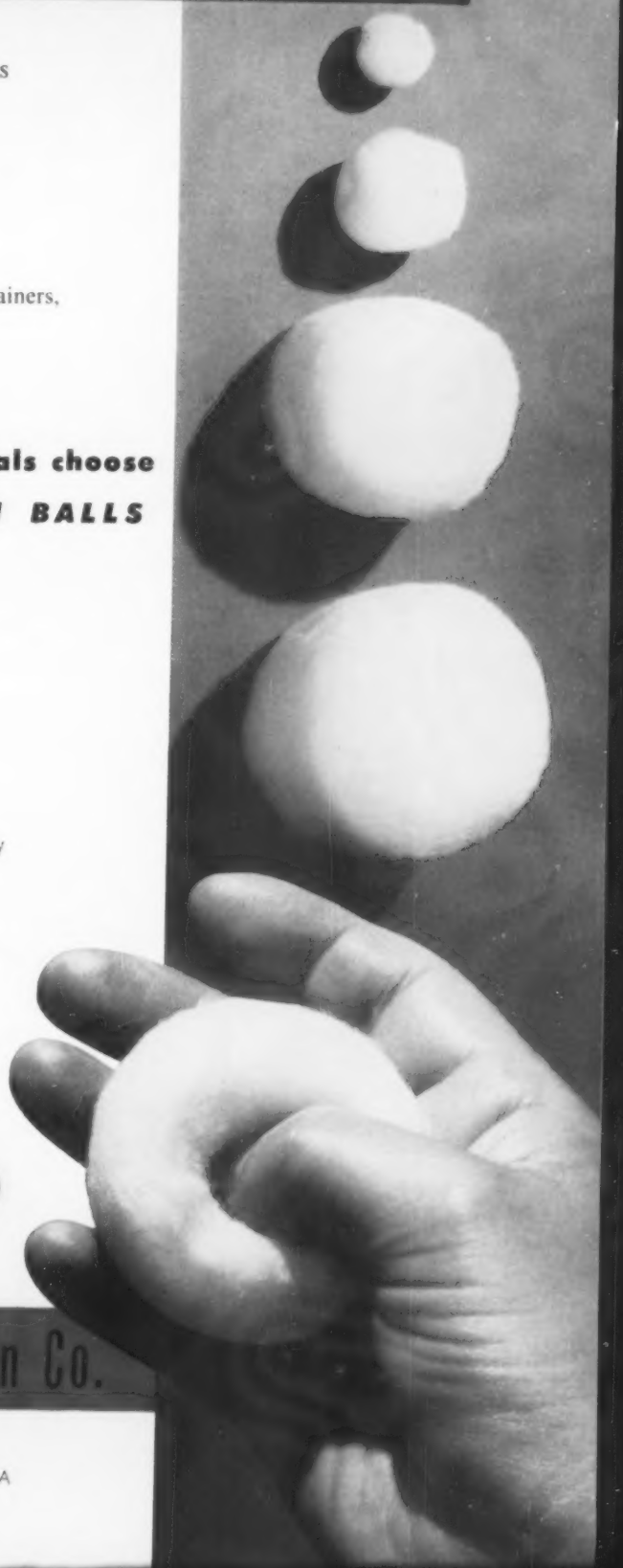
1. Uniform in size and shape
2. Firm, compact construction
3. Made of finely spun, selected long staple cotton
4. Highly absorbent
5. Labor-saving—ready for immediate use after sterilization
6. Actually more economical to use than "home-made" cotton balls or other manufactured balls of same high quality
7. Available in *5* standard sizes:

super	2000 per case
special	2000
large	2000
medium	4000
small	8000

special is same size as large but is almost twice as dense

WRITE FOR SAMPLES, INFORMATION, PRICES

manufactured
where grown...



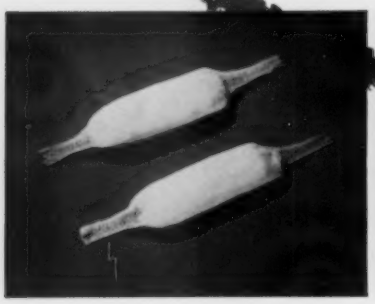
Carolina Absorbent Cotton Co.

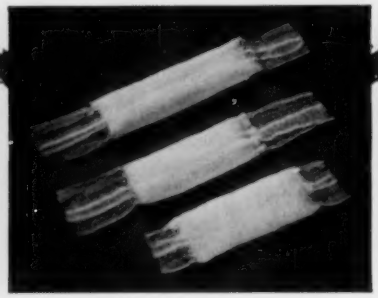
(Division of Barnhardt Mfg. Co., Inc.)
CHARLOTTE 1, NORTH CAROLINA

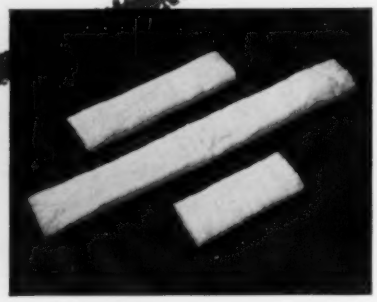
patient comfort *Plus* **hospital economy**

Carolina Sanitary Napkins

● Carolab's *cotton*-filled sanitary pads are made from quality materials as carefully processed and treated as Carolab's famous surgical cotton. They do not shrink or become brittle or discolored when sterilized. Heat actually improves them . . . makes them thicker and fluffier to provide the downy-soft comfort and maximum absorptive qualities so important in surgical and obstetrical cases.







Best OF ALL

Cotton-filled, stockinette covered: a soft but sturdy, tubular-knitted casing which completely encloses the cotton . . . convenient, comfortable—no seams, no overlap. Available in all standard hospital sizes with regular tabs.

Best IN ITS CLASS

Cotton-filled, gauze covered: same fine, soft, absorbent cotton, wrapped in good quality gauze. In all standard hospital sizes with regular tabs; regular size with short tab.

WRITE FOR SAMPLES, INFORMATION, PRICES

Best FOR THE MONEY

Tabless, cotton-filled: gauze covered, most economical of all cotton pads. In three convenient sizes: 3½"x8", 3½"x12", and 3½"x24". **Also available—cellulose-filled:** gauze covered, with tabs—an economical substitute for cotton. Four styles: regular, with short or long tabs; senior, with long tabs; hospital, 12" with long tabs.

CAROLAB Hospital Supplies

Carolina Absorbent Cotton Company

(Division of Barnhardt Mfg. Co., Inc.)

CHARLOTTE 1, NORTH CAROLINA

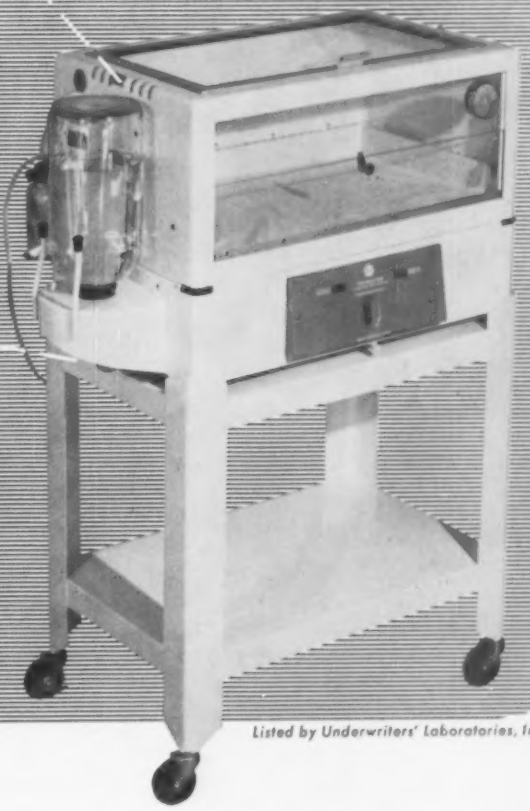
An E&J INCUBATOR *Plus Value!*

FIVE DAY *always visible* WATER SUPPLY

HELPS MAINTAIN

BALANCED TEMPERATURE & HUMIDITY

THREE WAYS



1 Eliminates frequent opening of crib to check or refill water pan.

2 Eliminates disturbance of humidity production caused by sudden addition of unheated water.

3 Maintains constant water level in pan to insure equalized production of humidity.

AND IN ADDITION PROVIDES...

★ Major saving of nurses' time and effort.

★ Check of water level at a glance from any part of Nursery.

★ Greater assurance that the water supply will not be inadvertently overlooked or exhausted.

Listed by Underwriters' Laboratories, Inc.

SALES & SERVICE AT THE LOCAL LEVEL THROUGH HOSPITAL SUPPLY DEALERS

It is simple but effective design throughout, like the feature described above, that makes E & J Incubators high in performance and low in price. Details of both are yours for the asking; by a brochure sent immediately, or a free and complete demonstration in your Nursery. Just write or wire E & J, Dept. 552-2MHP, at the address below.

the **NEW** *name in Incubators!*

E&J

E & J MANUFACTURING COMPANY

100 East Graham Place • Burbank, California

construction of more veterans hospitals but under present Administration plans, it is unlikely that the Veterans Administration construction program will be expanded.

The Veterans Administration is now operating 172 hospitals which provide annual care for nearly 500,000 patients including 105 clinics serving 145,000 veterans a month. In the Eisenhower budget request for health and medical programs for fiscal 1956, the total for the Veterans Administration was $940,890,000. Out of this amount, $60 million was asked for hospital construction for the repair and maintenance of existing structures.

Hill-Burton Appropriations. The Presidential recommendation for Hill-Burton appropriations in the Eisenhower budget for 1956 was set at a figure of $125 million for both phases of the hospital construction program. The $125 million figure is broken down as follows: basic Hill-Burton construction, $65 million; diagnostic or treatment centers, $20 million; hospitals for the chronically ill, $20 million; nursing homes, $10 million, and rehabilitation facilities, $10 million.

SEPTISOL
with HEXACHLOROPHENE 0.75%
Is best for...
The use of SEPTISOL Antiseptic liquid soap for scrub up, preoperative prep, routine hand washing, and food handling assures surgical cleanliness at all times.
SEPTISOL'S cumulative action keeps on killing bacteria—even many hours after washing.
SEPTISOL is non-irritating to the normal skin. Natural vegetable emollient leaves hands and skin soft and surgically clean.
ACCEPTED
Vestal
INCORPORATED
4963 MANCHESTER AVE.
ST. LOUIS 10, MISSOURI
SCRUB UP
PREOPERATIVE PREP
ROUTINE HAND WASHING
FOOD HANDLING

Federal Employees Insurance. The Administration's plan for health insurance for federal employees has not yet been introduced into Congress. Last year's proposal was essentially a Blue Cross program providing for employee participation in local health insurance plans. The central feature of the Administration's new plan would be a straight cash indemnity proposal based on a schedule of benefits set by the Civil Service Commission. It would include:

1. Reimbursement for hospital room up to $12 per day for maximum of 70 days.
2. Other hospital cost allowances up to a total of $240.
3. Reimbursement for surgery up to a maximum of $200 under schedule set by the Civil Service Commission.
4. Flat $150, for any maternity.
5. Up to $3 per day for physicians' charges while the patient is in hospital.
6. Maximum of $50 per calendar year per person for out-of-hospital, ambulatory, diagnostic, x-ray examinations and laboratory analyses.
7. Seventy-five per cent of major medical costs up to a maximum of $2,500 with a $100 deductible.
8. Privilege of continuation of insurance coverage after retirement provided employee has a minimum of 15 years civilian service.

The standard plan will become operative when 600,000 of the nearly two million eligible government workers agree to participate. Each employee has the right to pass up the standard plan and participate instead in a Commission-approved local plan such as Blue Cross or Blue Shield. While the federal employees may participate in only one type of plan, he has three local options open to him other than the nationwide standard policy. These three alternatives are: (a) local personal health service plans, Blue Cross, etc.; (b) the local federal employees union plan, or (c) local cash indemnities commission group plan.

Legislation Check List. Among the many health bills now being taken up by the Congress, the following check list provides a ready reference for the more important measures which will be of direct concern to hospitals:

Federal Payroll Deductions

S. 9—CARLSON (R., KAN.)

Identical to the Administration bill introduced last year to authorize federal agencies to make available voluntary health insurance benefits for

federal employees with the government participating in the cost up to a limit of $26 for the federal share. This bill emphasizes local option. The Administration has rejected this approach and will shortly introduce a new bill emphasizing a standard nationwide comprehensive plan.

Federal Pay

S. 67—JOHNSON (D., S.C.)

Would increase pay of federal employees.

Aid to Medical Education and Health Facilities

S. 434—IVES (R., N.Y.), FLANDERS (R., Vt.) and CASE (R., N. J.)

This is a reintroduction of the popular Ives-Flanders bill introduced several years ago. It would provide federal funds to states to:

1. Assist in financing voluntary prepayment health service plans with subscription charges based on subscribers' incomes.
2. Assist nonprofit hospitals, medical schools and nursing schools to maintain and improve service facilities.
3. Assist voluntary prepayment plans in equipping health service centers.
4. Assist medical education.
5. Assist local public health units.

Old-Age Assistance

S. 658—IVES (R., N.Y.)

Would establish a commission to study programs for the aged, including health programs.

Taxes

H.R. 2—MCCORMACK (D., MASS.)

Would boost allowable charitable contributions by corporations for income tax purposes to ten per cent instead of five per cent.

Taxes

H.R. 9—JENKINS (R., OHIO)

Would encourage establishing voluntary pension plans by allowing self-employed persons to deduct ten per cent of earned net income up to $7,500 a year but not to exceed $150,000 in a lifetime. Funds would have to be paid to a restricted retirement fund on an annuity contract.

Taxes

H.R. 28—COUDERT (R., N. J.)

Similar to H.R. 9. Would assist individuals to provide retirement income and protection to surviving members of their families by allowing a limited income tax deduction for premiums paid on annuities and life insurance contracts.

Health Insurance

H. Res. 48—MULTEN (D., N.Y.)

Would provide for Congressional committee investigation of accident, health and hospitalization insurance organizations.

Military Medical Scholarships

H.R. 67—BENNETT (D., FLA.)

Would finance training of candidates for appointments as physicians and dentists in the Armed Forces. Such candidates would be required to serve on active duty one year for each year of schooling or for a three-year period, whichever is longer. Scholarships would include maintenance allowances. The expected Administration bill on this subject has not been introduced.

Compulsory Health Insurance

H. R. 95—DINGELL (D., MICH.)

This is the controversial national compulsory health insurance omnibus bill that has been introduced for several Congresses. It would provide for such things as compulsory, prepaid, personal health insurance, federal aid to medical education, medical research, hospital construction, special aid for rural health service and maternal and child health care.

Taxes

H.R. 267—COUDERT (R., N.Y.)

Would permit tax deductions for the self-employed of 15 per cent of annual earned net income up to $10,000 provided payments are made to a restricted retirement fund.

Taxes

H.R. 335—MCDONOUGH (R., CALIF.)

Would allow more liberal income

J&J new design
POST-OPERATIVE STRETCHER

Incorporates all the advantages of present models, plus these two optional features:

1 Sponge Rubber Shoulder Rests, to prevent patient from sliding backward when stretcher is in Trendelenburg position.

outstanding features throughout

- Side rails may be elevated ½ way or to full 15" height.
- Mid-position catch *must be released* before rail can be lowered.
- End rail, easily removable, may be positioned at either end or stored under unit.
- Provision for arm rests and restraining straps.
- New Sponge Rubber Shoulder Rests prevent slipping.
- Adjustable 3-position Back Rest.
- Smooth-action elevating mechanism either horizontally, to Trendelenburg, or to reverse Trendelenburg positions.
- Double ball-bearing swivel casters with 10" adjustable, ball-bearing, rubber-tired wheels.
- One caster at either end with dual control locking mechanism.
- Unit electrically conductive throughout.

2 Adjustable Back Rest to allow patient to sit in semi-reclining position (heart attacks, thyroid drainage, X-rays). Wood panel construction permits X-rays of upper body without disturbing patient.

Available: (a) entirely painted; (b) entirely painted, except with stainless steel side rails and stainless steel removable end rail; (c) entirely of stainless.

Send for complete information.

Jarvis AND Jarvis

Manufacturers of Noiseless Trucks and Casters • PALMER, MASSACHUSETTS

6J2559

tax deductions for payments for health insurance, not to exceed $200 a year.

Social Security—Public Assistance

H.R. 375—FORD (R., MICH.)

This bill would permit payment of federal funds to those three classes of categorical recipients who are patients in private medical institutions, which are now eligible for such payments. Present law permits payments to such patients only if they are in public medical institutions.

Hospital Loans

H.R. 397—WOLVERTON (R., N.J.)

Would amend the Public Health Service Act by providing mortgage loan insurance for hospitals and other medical facilities.

Hospital Loans

H.R. 398—WOLVERTON (R., N.J.)

Would provide mortgage loan insurance for hospitals and other medical facilities devoted mainly to voluntary health prepayment plans. This bill is similar to H.R. 7700, introduced in the last Congress which was popularly labeled as the Wolverton-Kaiser bill. A $2.5-million Medical Facilities Mortgage Fund would be created to be administered by the Surgeon General of the Public Health Service. Fund would insure outstanding mortgages up to a total of $300 million. Each mortgage could not exceed $5 million nor 90 per cent of value of property nor bear interest in excess of 5 per cent. Not less than 60 per cent of the insured medical facility must be devoted to serving members of group practice and prepayment health plans. Insurance premiums would be set at 1.5 per cent or such lesser amount as the Surgeon General deems feasible.

Loans to Health Associations

H.R. 399—WOLVERTON (R., N. J.)

A bill identical to one introduced in last Congress to assist voluntary, nonprofit associations offering prepaid health service programs to secure facilities and equipment through longterm government loans.

Reinsurance

H.R. 400—WOLVERTON (R., N. J.)

Identical to last year's administration reinsurance bill, H.R. 8356, which was voted down in the House 237-134. The Administration's revised reinsurance proposal will be submitted later.

Reinsurance

H. R. 401—WOLVERTON (R. N. J.)

Similar to H.R. 400 except that eligibility is restricted to nonprofit associations offering health insurance or rendering health services.

Taxes

H.R. 402—WOLVERTON (R., N. J.)

Permits income tax deductions for health insurance without regard for the present three per cent limitation up to $100 for exemption.

Federal Grants-in-Aid

H.R. 403—WOLVERTON (R., N.J.)

This is the same grants-in-aid bill proposed by the Administration in the last Congress and passed the House but died in the Senate Committee. It would replace separate federal health grants to states with block grants which would:

1. Assist states generally in meeting the cost of public health services.
2. Assist states to extend and improve their public health services.
3. Assist public and other nonprofit organizations and agencies to meet costs of unique projects aimed at the solution of regional or national public health problems.

Aid to Medical Education and Health Facilities

H.R. 481—SCOTT (R., PA.)

Bill is identical to the old Ives-Flanders bill of last Congress. For more detailed provisions see S. 434.

Health Insurance for the Aged

H.R. 638—CELLER (D., N.Y.)

This bill is the old Ewing proposal to include in OASI benefit payments of hospitalization up to maximum of 60 days a year. Private insurance plans could be used.

Servicemen's Dependents

H.R. 2685—VINSON (D., GA.)

This bill is similar to one introduced last year and would provide for hospital and medical care by civilian hospitals and doctors where military facilities are not available. It would implement recommendations of the Moulton Commission set up two years ago to study the problem. Dependents would pay for civilian health services the first $10 of the cost of each illness plus ten per cent of the total bill. This is the Administration's proposal.

Doctor Draft

H.R.— 2886—VINSON (D., Ga.)

Would extend doctor draft law two years to July 1, 1957.

Appoint Committee To Counsel Social Security Administration

The appointment of a 15-member Medical Advisory Committee to counsel the Social Security Administration on medical aspects of administering the new "disability freeze" provision in the social security law, has been announced by Charles I. Schottland, Commissioner of Social Security.

The "disability freeze" provision is similar to the waiver of premium in commercial life insurance and permits a worker to keep his old-age and survivors insurance rights intact when he is totally disabled for work for an extended period.

Many of the country's hospitals, and their outpatient departments, will be affected by this development, since determinations will have to be made of the nature of an applicant's physical disability. Individuals adjudged to be totally disabled within the law's meaning will have their social security status "frozen," resulting in their receiving larger monthly benefits when they reach retirement age.

The Medical Advisory Committee will help the Bureau of Old-Age and Survivors Insurance of the Social Security Administration to set up guides and procedures for obtaining and interpreting medical evidence as to existence and extent of disability. Dr. J. Duffy Hancock, professor of clinical surgery at the University of Louisville School of Medicine, is chairman of the Committee.

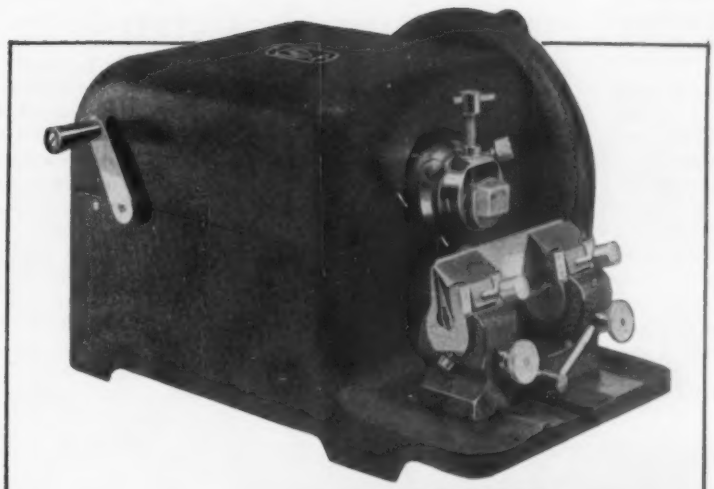
OFFICIAL NOTES

(Continued from page 157)

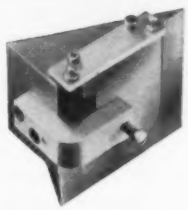
A question was raised concerning the most expeditious way for handling review and presentation of testimony on the many federal health legislative proposals which as anticipated will be presented to Congress within the near future. It appeared impractical to expect the entire Board to be called into session at frequent intervals. It was agreed that a mechanism should be developed whereby policy interpretation might be formulated on behalf of the Board when necessary.

VOTED: To authorize the president to appoint a Committee to Consider Legislation on Health Matters which will act preferably upon advice of the Council on Government Relations and further,

That such committee shall have authority to act on behalf of the Board of Trustees with the understanding that conference telephone calls to the Board of Trustees may be arranged in the event major policy issues are involved in the decisions of the Committee. (Subsequent to the meeting, the president appointed the following



AO MICROTOMES
TIMELESS PRECISION!



ULTRA-THIN
Sectioning Adapter No. 829

For use in electron microscopy, ultra-thin sectioning of biological tissue can be accomplished with the use of the No. 829 Adapter which changes the feed advancement from one micron to 1/20th micron.

LONG-TERM accuracy and dependability are the key to the universal popularity of these durable AO Microtomes. The No. 820's well-deserved reputation for continued precision sectioning has placed it in almost every laboratory responsible for this type of work.

Underlying the success of these microtomes is their complete reliability in cutting thin sections, a consistency achieved and maintained in the following manner.

First, the horizontal feed mechanism is entirely independent of the vertical movement of the specimen, eliminating vibration as a source of sectioning irregularity. Capable of feeding specimens from one to fifty microns thick, the No. 820 Microtome makes uniform serial sectioning a routine performance.

Second, materials are critically chosen and carefully tested, while parts are close-fitted by skilled craftsmen, long experienced in making fine microtomes. The result is a rigid, heavily-constructed precision instrument, with built-in longevity. Since this is the case, the cost per tissue section is reduced to a negligible amount.

A precision-edged, high-quality steel knife, complete with back and handle for sharpening, is supplied.

American Optical
INSTRUMENT DIVISION
BUFFALO 15 NEW YORK

Dept. O 200

Please send me Catalog I-16 which gives complete information on AO No. 820 Microtome.

Name_____

Address_____

City_____ Zone_____

State_____

members to this Committee: Tol Terrell, chairman; Dr. C. C. Hillman, and Mary C. Schabinger. Also as advisors to the Committee representing the Council on Government Relations, he appointed Dr. Lucius R. Wilson, J. Douglas Colman and Kenneth Williamson.)

VOTED: That the American Hospital Association goes on record at the appropriate time as being gravely concerned lest an unsound approach to the problem of health insurance for federal employees vitiate the effort that the Association has been making over the years to promote sound, non-profit, health coverage for the American people on a service basis.

COVERAGE FOR FEDERAL EMPLOYEES

There was discussion of the difficulties Blue Cross Plans are having in offering as a package plan the kinds of health coverage demanded by the Civil Service Commission and other national organizations under a national program for health protection of federal employees. There was general agreement that extension of the offerings of individual Blue Cross Plans to meet the demands of large national groups requires changes in present practices. These changes can be made by Blue Cross Plans only with hospital concurrence and only if Plans are willing to modify their local programs to fit a national pattern.

VOTED: To adopt the following resolution for distribution to Institutional Members Types I, II and IV of the American Hospital Association:

WHEREAS a basic justification for continuing voluntary methods of providing health services has been a belief in the ability of hospitals and the professional medical disciplines to provide medical care to all the people; and

WHEREAS Blue Cross is the vehicle developed and sponsored by hospitals to permit the public to budget voluntarily for hospital care through prepayment; and

WHEREAS a major objective of Blue Cross and of the American Hospital Association is to extend the application of the principle of group payment for hospitalized illness; and

WHEREAS it sometimes is necessary for Blue Cross to deviate from local benefit provisions in order to offer acceptable contracts to national groups; and

WHEREAS Blue Cross must have confidence in local hospital acceptance of national contracts with special benefit provisions, therefore be it

RESOLVED that the American Hospital Association urge hospitals to evidence their confidence in the voluntary system of financing hospital care by supporting Blue Cross through acceptance of uniform benefit provisions of national contracts, and be it further

RESOLVED that Blue Cross Plans be urged to evidence their support of hospitals' interests by modifying local practices sufficiently to enable the development of uniform benefit provisions in national contracts.

EXTENSION OF BENEFITS

VOTED: To request the Blue Cross Commission to study the possibility and advisability of including in Blue Cross benefits the care of pulmonary tuberculosis while in the early acute stages and of mental illness while in the early definitive stages.

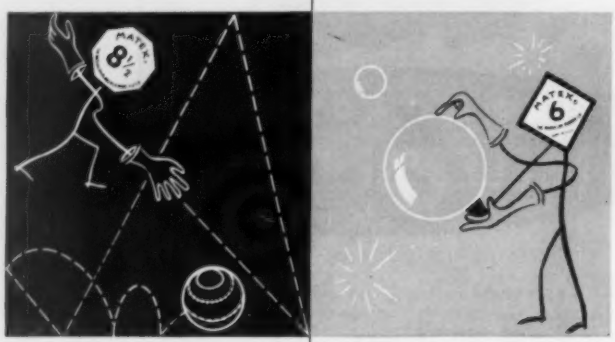
APPROVAL OF BLUE CROSS PLANS

VOTED: To approve Tidewater Hospital Service Association, Norfolk, Va., as a Blue Cross Plan for 1955.

VOTED: To approve the following 54 Plans as Blue Cross Plans for the year 1955 and to commend them for their full compliance with the approval standards of the American Hospital Association:

YOU BENEFIT

from this compromise



LET'S FACE FACTS

The Massillon Rubber Company *could* make surgeons' gloves with higher tensile strength that would last even longer than they do. Or they *could* make gloves even thinner . . . that wouldn't last as long.

A balanced compromise between these two extremes is the practical answer.

In MATEX (white) and MASSILLON Latex (brown) you get the delicate balance of long glove life and comfortable, bare-fingered tactility that supplies the most in satisfaction, long service and economy.

And the KWIKSORT permanent size markings cut your labor costs. An untrained assistant can sort and pair KWIKSORT sizes by shape—even when gloves are inside out!

May we send the free folder, "Suggestions to make your gloves last longer"? You'll get extra use from gloves that are cared for properly.

MATEX Kwiksort MASSILLON LATEX

The

What in the world do they talk about at hospital board meetings ?

Staff problems, new equipment, personnel — certainly. But often about money. The need for funds. How to get them.

Almost every hospital is faced with the need for more money than it has — money for new building, money for expansion, money for rehabilitation, money for debt reduction.

If your Board is worrying its way through a financial problem alone, they owe it to themselves and the institution to consult fund-raising counsel.

Whether your hospital needs three million dollars or far less, Lawson Associates meets and solves problems just like yours every day, year after year.

Lawson Associates is an organization of trained and experienced specialists whose planning and direction of your funds campaign can save you time, effort and worry — and produce enormously more than you could by going it alone. Our survey of your area of service, our analysis of your fund-raising potential and our preparation of a proposed Plan of Campaign are yours without obligation.

WRITE TODAY for a fact-filled brochure, "When Your Hospital Needs Funds." Address: Lawson Associates, Rockville Centre, New York. Attention, Mr. Fraser.

Lawson Associates
INCORPORATED

FUND RAISING COUNSEL — ROCKVILLE CENTRE, NEW YORK

Blue Cross-Blue Shield of Alabama, Birmingham
Arkansas Medical and Hospital Service, Inc., Little Rock
Hospital Service of Southern California, Los Angeles
Hospital Service of California, Oakland
Group Hospital Service, Inc., Wilmington, Del.
Group Hospitalization, Inc., Washington, D. C.
Blue Cross of Florida, Inc., Jacksonville
United Hospital Service Association, Atlanta, Ga.
Georgia Hospital Service Association, Inc., Columbus
Hospital Service Association of Savannah (Ga.)
Idaho Hospital Service, Inc., Boise
Hospital Service Corporation, Chicago
Mutual Hospital Insurance, Inc., Indianapolis, Ind.
Hospital Service, Inc. of Iowa, Des Moines
Kansas Hospital Service Association, Inc., Topeka
Blue Cross Hospital Plan, Inc., Louisville, Ky.
Hospital Service Association of New Orleans (La.)
Associated Hospital Service of Maine, Portland
Maryland Hospital Service, Baltimore
Group Hospital Service, Inc., Kansas City, Mo.
Group Hospital Service, Inc., St. Louis
Hospital Service Association of Montana, Great Falls
Nebraska Blue Cross Hospital Service Association, Omaha
Associated Hospital Service of Capital District, Albany, N. Y.
Hospital Service Corporation of Western New York, Buffalo
Chautauqua Region Hospital Service Corporation, Jamestown, N. Y.
Associated Hospital Service of New York, New York City
Rochester (N. Y.) Hospital Service Corporation
Group Hospital Service, Inc., Syracuse
Hospital Service Corporation of Jefferson County, Watertown, N. Y.
Hospital Care Association, Inc., Durham, N. C.
Hospital Service, Inc., Lima, Ohio
Hospital Service Association of Toledo (Ohio)
Group Hospital Service, Tulsa, Okla.
Northwest Hospital Service, Portland, Ore.
Hospital Service Plan of Lehigh Valley, Allentown, Pa.
Hospital Service Association of Northeastern Pennsylvania, Wilkes-Barre
Tennessee Hospital Service Association, Chattanooga
Memphis (Tenn.) Hospital Service & Surgical Association, Inc.
Group Hospital Service, Dallas, Tex.
Intermountain Hospital Service, Salt Lake City, Utah
Piedmont Hospital Service Association, Lynchburg, Va.
Virginia Hospital Service Association, Richmond
Associated Hospitals, Inc., Bluefield, W. Va.
Hospital Service, Incorporated, Charleston, W. Va.
Blue Cross Hospital Service, Huntington, W. Va.
West Virginia Hospital Service, Inc., Wheeling
Associated Hospital Service, Inc., Milwaukee, Wis.
Wyoming Hospital Service, Cheyenne
Blue Cross of Puerto Rico, San Juan
Alberta Blue Cross Plan, Edmonton
Manitoba Hospital Service Association, Winnipeg
Blue Cross Plan for Hospital Care, Toronto
Quebec Hospital Service Association, Montreal

VOTED: To approve the following 25 Plans as Blue Cross Plans for 1955, recognizing that they are in substan-

New

PARCOA

System

Operates Hospital Parking Lots

Automatically

WITHOUT ATTENDANTS

Here's the practical solution to your hospital parking problem, as already proved in actual service.

The amazing new PARCOA system does the job safely, economically and dependably—without attendants. A simple electrical mechanism controls entrance and exit gates, actuated by card-keys* issued only to authorized holders.

PARCOA equipment is low in first cost. Easy to install. Requires minimum maintenance. No attendants needed. No help problem. Coded card-key can be changed as desired.

Write today for illustrated brochure and name of nearest distributor. Technicolor sound film available for special showing to your group.

*Your choice of controls (coin, card or any combination) makes this system readily adaptable to your requirements.

PARCOA

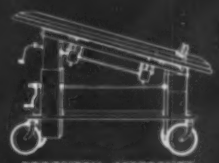
PARKING CORPORATION OF AMERICA

Division of Johnson Fare Box Company

4619 North Ravenswood Avenue, Chicago 40, Illinois

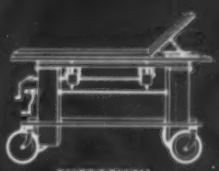
Sales and Service Offices in Principal Cities listed under BOWSER, Inc.

SHAMPAINE *Trans-All* DOES ALL THIS-



RECOVERY STRETCHER
—Trendelenberg position

REVERSE TRENDELENBERG



EMERGENCY TREATMENT TABLE
—all height adjustments

OVER-BED PATIENT TRANSFER
—tilts to right or left

AND MANY OTHER USES!

--and ONE ATTENDANT easily performs all over-bed transfer and transport functions with SINGLE END CONTROLS.

The TRANS-ALL is the perfect stretcher for Recovery Room use, and bypasses the need for intermediate transfer during the entire Recovery Room period. For all purposes, the TRANS-ALL is a versatile, comprehensive stretcher for every hospital.

Shampaine COMPANY

MANUFACTURERS OF A COMPLETE LINE OF PHYSICIANS' AND HOSPITAL EQUIPMENT

SHAMPAINE COMPANY, Dept. H5-3
1920 South Jefferson
St. Louis 4, Missouri

Please send literature on the new Shampaine TRANS-ALL Stretcher.

My dealer is.....

Name.....

Address.....

City..... Zone..... State.....

tial compliance with the Approval Standards of the American Hospital Association:

Colorado Hospital Service, Denver
Louisiana Hospital Service, Baton Rouge
Massachusetts Hospital Service, Inc., Boston
Michigan Hospital Service, Detroit
Minnesota Hospital Service Association, St. Paul
Mississippi Hospital and Medical Service, Jackson
New Hampshire-Vermont Hospitalization, Concord, N. H.
Hospital Service Plan of New Jersey, Newark
Hospital Plan, Incorporated, Utica, N. Y.
Hospital Saving Association of North Carolina, Chapel Hill
North Dakota Hospital Service Association, Fargo
Akron (Ohio) Hospital Service
Hospital Service, Inc., of Stark County, Canton, Ohio
Hospital Care Corporation, Cincinnati
Central Hospital Service, Columbus, Ohio
Associated Hospital Service, Inc., Youngstown, Ohio
Capital Hospital Service, Harrisburg, Pa.
Associated Hospital Service of Philadelphia
Hospital Service Association of Pittsburgh
Hospital Service Corporation of Rhode Island, Providence
Hospital Service Association of Roanoke (Va.)
Washington Hospital Service, Seattle
Marion County Hospital Service, Inc., Fairmont, W. Va.
Parkersburg (W. Va.) Hospital Service, Inc.
Maritime Hospital Service Association, Moncton, N. B.

LISTING OF HOSPITALS

On January 20, 1955, a joint letter from the headquarters of the American Hospital Association and the American Medical Association was sent to all hospitals formerly registered by the American Medical Association, notifying them of termination of the registration program by the American Medical Association. *(For text of letter see page 158-160.)* Also the hospitals were advised that the American Hospital Association would continue its program of listing acceptable hospitals and of accumulating statistical information about hospitals.

The staff of the Association has been engaged in the formulation of procedures for listing acceptable hospitals by the Association. It is contemplated that surveys of hospitals for listing in the Association publication ultimately will be conducted by Association surveyors who are field representatives of the Joint Commission on Accreditation of Hospitals and that methods for consultation with various agencies within each state will be established to assist headquarters staff in the conduct of the listing project. The list will be published in August 1955 and in succeeding years.

***VOTED:** That the first annual list of hospitals published by the American Hospital Association will include, without survey, all hospitals registered in the 1953 census of hospitals, published by the American Medical Association, in the May 1954 hospital number of The Journal of the American Medical Association provided no recent information indicates their eligibility for such listing has changed; further*

Such additional hospitals whose compliance with eligibility standards

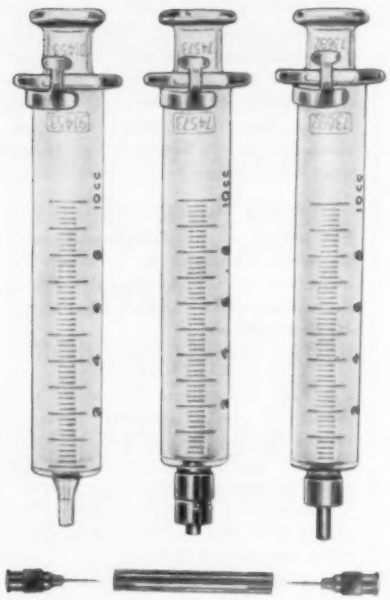
Identified — by NAME

Baby's first award . . . a necklace of Deknatel Name-on-Beads . . . removing all doubt as to identity. These attractive, sanitary beads are made with the same precision and craftsmanship as a piece of jewelry. The black letters, which appear on both sides of the beads are permanently fused into the white enamel bead. Not affected by washing or sterilizing. Used by America's leading hospitals for more than 30 years.

J. A. Deknatel & Son—manufacturers of surgical sutures and operating room specialties—96-20 222nd St., Queens Village 29, (L.I.) New York.

DEKNATEL
NAME-ON-BEADS
"the original" since 1920

Buy Eisele Hypodermic Syringes and Needles ... and SAVE



Eisele Hypodermic Syringes

With either matched or interchangeable barrels and plungers, Eisele syringes are precision built to prevent leakage and flow-back. Heat hardened ***five times*** for longer wear and less breakage.

Luer Lock, Metal or Glass tips are the same price.

Typical syringe prices:

2cc matched syringe with repair exchange	**$11.76** per dozen
2cc matched syringe without repair exchange	**$13.07** per dozen

10% discount on orders of three gross or more.

Eisele Hypodermic Needles

Hand-honed, side beveled under a magnifying glass for less tissue trauma, Eisele needles are individually inspected for temper, fit and sharpness. A full range of sizes and materials.

Typical needle prices:

25 gauge ⅝ inch rustless needles complete with tube protectors	**$11.51** per gross

The Eisele policy of selling direct means better syringes and needles at lower cost.

***Complete satisfaction guaranteed*—Order the syringes and needles you need from—**

EISELE and COMPANY

400 1st Ave., No., Nashville, Tennessee

Have a Coke

AND NOW
Continental's
LOW COST, SPACE SAVING
BED LAMP . . $7.25 EACH

MODEL E 730 . . PACKED 6 in Box

Firm yet Flexible Support Permits
Adjustment for DIRECT or INDIRECT SERVICE

FOCUSES LIGHT WHERE DESIRED . . ideal for semi-private rooms

LIGHT FIRMLY ANCHORED . . no tipping or tripping over cord

FELT-LINED CLAMP PROTECTS FINISH OF BED . . fits securely on square, round or graceline beds

SWITCH AT THE PATIENT'S HAND

LIFE-TIME METAL CONSTRUCTION with 8 ft. UL approved cord and switch

STATUARY BRONZE FINISH . . harmonizes with decorations

← Attaches to TOP or SIDE of Bed

TOMORROW'S LIGHTING SERVICE at YESTERDAY'S PRICE

WRITE FOR
ATTRACTIVE
QUANTITY
PRICES

Continental Hospital Service, inc.
18624 Detroit Ave. · Cleveland 7, Ohio

can be determined with reasonable assurance of accuracy prior to the deadline for printing may be included in the first annual listing.

VOTED: To appoint the members of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, appointed by the American Hospital Association, as a committee of the Board of Trustees to recommend acceptable hospitals for the annual hospital listing of the Association.

FOREIGN MEDICAL GRADUATES

VOTED: That the American Hospital Association approve in principle the objectives outlined by the Coöperating Committee on Graduates of Foreign Medical Schools.

METHODOLOGY

VOTED: To endorse the study proposed by the Operations Research Group at Ohio State University to develop a Methodology for the Evaluation of Patient Care,

Provided a formal request is received from the proper authorities of Ohio State University,

Provided that funds to finance this study are to be raised and administered by Ohio State University, and

Provided that endorsement of this project as a study of potential value to hospitals does not imply endorsement of the conclusions: further

To appoint an advisory committee, when funds to finance this study become available, to consult and advise with the study director, and that the committee have representatives of the Councils on Administrative Practice, Hospital Planning and Plant Operation and Professional Practice.

EMPLOYMENT INTERVIEWING

VOTED: To approve the recommendation of the Committee on Personnel Administration to make available to hospitals a training program for supervisors and a slide film and training guide on employment interviewing, such a project to be undertaken when funds are available from Association sources or from outside sources raised in accordance with the proposed Association policy.

CHANGE IN COMMITTEE NAME

VOTED: That the name of the present Committee on Financial Management be changed to the Committee on Accounting and Business Practices.

AUDITING STUDY

VOTED: To authorize the Committee on Accounting and Business Practices and the staff of the Association to work with the American Institute of Accountants and with an accounting

* Automatically!

Sani-Dri Electric Dryers

* **eliminate** needless towel costs!
(No more buying and storing of towels)

* **save** maintenance overhead!
(24-hour service—no waste to empty)

* **clean-up** littered washrooms!
(More sanitary! No fire hazard!)

No. 7-A Model. See catalog for recessed foot switch and other models

Even With Just 1 Washroom—
You Can Save, Too!

Savings are automatic with Sani-Dri! You eliminate 85% of washroom maintenance overhead PLUS 100% savings in towel costs. In addition, you get 'round-the-clock automatic drying service with greatly increased sanitation. Investigate this modern trend to low cost automatic drying now!

Write Today For Latest Facts!

Get the savings facts about Sani-Dri, the original and only complete line of dryers sold throughout the world. All models carry Underwriters' Seal and full 2-year guarantee. Write today!

Distributors in All Principal Cities

THE CHICAGO HARDWARE FOUNDRY CO.

"Dependable Since 1897"

3535 Commonwealth Ave.

NORTH CHICAGO, ILLINOIS

firm in developing a case study on auditing procedures for hospitals.

COUNCIL STAFF CHANGES

The director presented a letter from Allan D. Marshall resigning from membership on the Council on Administrative Practice. Mr. Marshall has recently changed employment and reluctantly concluded that his new duties would make it impossible for him to serve effectively as a member of the Council.

***VOTED:** To appoint James P. Dixon, M.D., Department of Public Health, Philadelphia, a member of the Council on Administrative Practice for a three-year term to expire in 1957.*

DR. DIXON

Moreland G. Smith has submitted his resignation as a member of the Committee on Hospital Architects' Qualifications because of pressure of business.

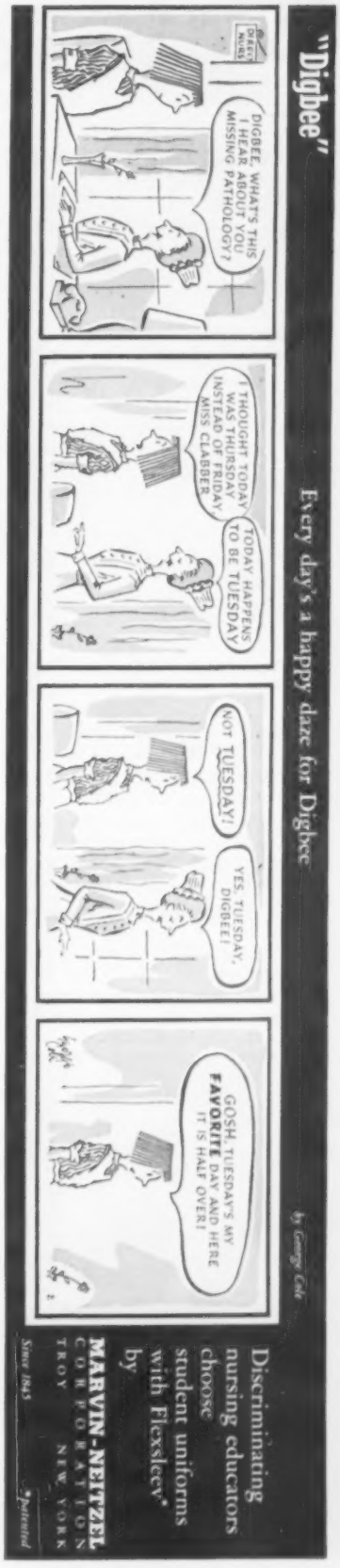
***VOTED:** To appoint Richard J. Adams, Montgomery, Ala., to membership on the Committee on Hospital Architects' Qualifications to fill the unexpired term (1956) of Moreland G. Smith.*

NURSING COST STUDIES

***VOTED:** That the following statement be added to the action taken by the Board of Trustees on December 10, 1954:*

In accordance with established policy, the appointment of representatives of the American Hospital Association to work in an advisory capacity with representatives of the Public Health Service and the National League for Nursing on the development of a practical method for determining the cost of basic collegiate nursing education programs shall not be interpreted as endorsement of any recommendations or methods for computing cost or for compensating for the maintenance of basic collegiate nursing education programs; further,

The American Hospital Association will be pleased to review any recommendations of the Public Health Service and the National League for Nursing on methods for determining the cost of basic collegiate nursing education programs, and to consider endorsement of these recommendations, provided they are compatible with the principles of hospital accounting and related policies previously adopted by the American Hospital Association.


"Digbee"
Every day's a happy daze for Digbee
by George Cole
DIGBEE, WHAT'S THIS I HEAR ABOUT YOU MISSING PATHOLOGY?
I THOUGHT TODAY WAS THURSDAY INSTEAD OF FRIDAY MISS CLABBER
TODAY HAPPENS TO BE TUESDAY
NOT TUESDAY!
YES, TUESDAY, DIGBEE!
GOSH, TUESDAY'S MY FAVORITE DAY AND HERE IT IS HALF OVER!
Discriminating nursing educators choose student uniforms with Flexsleev* by
MARVIN-NEITZEL CORPORATION
TROY NEW YORK
Since 1845
*Patented

Hospitals' Support: Key to Blue Cross Growth

(Editor's Note: This is the fourth in a series of articles on Blue Cross history, prepared especially for the 25th anniversary celebration of the Blue Cross idea.)

The phenomenal growth and public acceptance of Blue Cross within the past 25 years as the leading voluntary prepayment plan for hospital care hinges on one factor constant throughout Blue Cross history . . . the continued support of the nation's hospitals.

What today has developed into a working hospital-Blue Cross partnership in providing health care for the nation actually started in the late 1920's. At that time, U.S. hospitals were going deeply into debt because the American public could not afford the out-of-the pocket cost of hospitalization. More and more people became patients in tax-supported hospitals so that at one time the average use of voluntary hospital beds was less than 50 per cent of capacity. Hospital administrators as early as 1926 began seeking a solution to the problem of costs both to save themselves from possible bankruptcy and to help the public finance proper hospital care.

A partial solution to the problem was introduced in 1929 with the Baylor University Hospital Plan. The Baylor Plan attracted the attention of hospital directors throughout the nation because it was based on the idea of prepaying for actual hospital services rather than cash returns in case of hospitalization.

Reports on the growing group hospitalization movement were made before the American Hospital Association's annual conventions during the next four years. By 1933, three prepayment Plans similar to the Baylor Plan were in operation.

The American Hospital Association, aware of both hospital and public growing interest in group hospital prepayment, decided in 1933 through a vote of the Board of Trustees to encourage the movement. The AHA's first step toward assuring the quality of group hospitalization was to recommend standards for such an organization in a folder issued in 1933 called "Essentials of an Acceptable Plan for Group Hospitalization." Seven essentials listed as necessary characteristics for a Plan to maintain standards acceptable to the American Hospital Association were:

(1) Emphasis on public welfare, (2) limitation to hospital charges, (3) enlistment of professional and public interest, (4) free choice of physician and hospital, (5) nonprofit organization, (6) economic soundness, and (7) coöperative and dignified promotion.

By 1935—just two years after the American Hospital Association put its national support behind group hospitalization — combined enrollments in various Plans approached a quarter of a million persons in 50 U. S. cities.

Group hospitalization continued to grow at such a rapid rate the American Hospital Association requested from the Julius Rosenwald Fund a grant to establish a Commission on Hospital Service to coördinate further activities of group hospitalization. In 1936, the request was granted and the Commission established. The efforts of the Commission in guiding Plans in existence and in establishing new Plans were shown with the founding of 30 new Plans throughout the nation between 1937 and 1938.

On February 15, 1937, the American Hospital Association announced it had authorized associate institutional membership in the Association for nonprofit Plans meeting its membership standards. On April 1, 1938, the American Hospital Association formally approved 40 Plans as associate members of the Association.

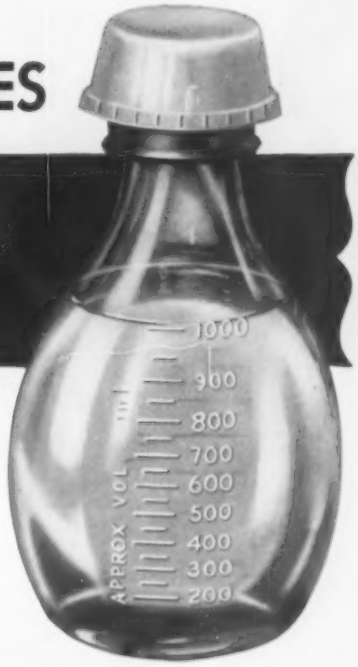
Through the American Hospital Assocation, the Blue Cross movement gained the support and prestige necessary for it to gain national prominence.

Today, the Blue Cross Commission—formerly the Commission on Hospital Service—is a trust within the corporate structure of the American Hospital Association. Of the 15 members of the Blue Cross Commission, 12 are elected by Plans from the 12 districts in the United States and Canada and three are appointed by the president of the American Hospital Association. The Commission's policies are subject to review and approval by the Board of Trustees of the American Hospital Association. The chairman of the Blue Cross Commission sits with the chairmen of the American Hospital Association Councils as a member of the Association's Committee on

AMERICA'S first Blue Cross baby, Mrs. Ann Woodard Reid, recently became the mother of her own Blue Cross baby, Michael Nathaniel, at North Carolina Memorial Hospital, Chapel Hill. Mr. Reid (second from left) is shown with his family as they accept a layette from Elisha M. Herndon, executive vice president of Hospital Care Association, Inc., Durham, N. C. When the Durham Blue Cross Plan paid for Ann's birth in December 1933, it was the first time maternity care ever was included in benefits extended by a hospital prepayment plan.

MACALASTER BICKNELL
Parenteral Corporation
CAMBRIDGE 39, MASSACHUSETTS

INTRODUCES



MacBick SELF-SEALING POUR-O-VAC

Macalaster Bicknell research presents a significant improvement in the Pour-O-Vac Technique . . . already America's most widely used sterile fluid flasking method.

- **NEW SELF-SEAL POUR-O-VAC CAP MAY BE USED WITH EXISTING POUR-O-VAC COLLARS AND FLASKS**

  Self-sealing cap of pure nylon is virtually indestructible. It's easy to handle and specifically designed to conform to *approved aseptic technique* because there are no hard-to-clean recesses. Placed on container before sterilization, it is held in place during sterilization and then automatically seals by vacuum at end of cycle.

- **PEAR SHAPE FLASK — PROVEN STRUCTURALLY STRONGER**

  Pear-shaped Pyrex flask is strongest, safest container for sterilizing fluids known to science. Glass bottles are really bubbles blown of liquid glass inside an iron mould. The more a mould distorts the natural shape of the bubble, the more inherent weak spots there will be in the bottle. The pear shape is the *natural shape* . . . for strength, and for ease of handling.

Branch offices: Chicago, Ill.; Columbus, Ohio; Millville, N. J.; New Haven, Conn.; New York, N. Y.; Shreveport, La.; Syracuse, N. Y.; Washington, D. C.

ORIGINAL DISTRIBUTORS OF THE FENWAL SYSTEM

ONLY NORRIS GIVES YOU AN EXTRA BUILT-IN POWER OUTLET!

PREFERRED FOR HOSPITAL FOOD SERVICE-The NORRIS DELUXE MILK DISPENSER

Hospitals throughout the United States have found that Norris Deluxe dispensers speed milk service and give patients a colder, tastier glass of milk. A Norris dispenser with its self-contained refrigeration unit, releases needed refrigeration space for other use. Service time is cut, more milk is consumed, and the dispensers pay for themselves in savings on the lower cost of bulk milk over packaged milk.

LOOK TO NORRIS FOR A COMPLETE LINE OF QUALITY DISPENSERS
All stainless steel with sealed, self-lubricating refrigeration units

MODEL N-5-SS | MODEL N-10-SS | MODEL N-15-SS

Show me how a Norris Dispenser can help me *save* more . . . *profit* more!

Name_____

Company_____ Title_____

Address_____

City_____ State_____

H355

Norris DISPENSERS, inc.
Dept. H355, 2720 Lyndale Ave. So.
Minneapolis, Minnesota

GERMS ARE HITCHHIKERS—

deadly ones!

Stop giving germs a free ride on your hands. If you're in a hospital, your hands should be kept nearly germ-free, for that's one practical way to cut down the transmission of contagious bacteria.

Surgeons recognize the vital need for good asepsis in wards and kitchens just as they do in the operating suite. Until recently it was not practical because scrub-up was an arduous, time consuming job, difficult to accomplish.

Today modern science provides a time-saving, highly efficient germicide for soap . . . *and Huntington makes its use practical throughout the hospital.*

Germa-Medica with Hexachlorophene is the soap you need. It is a proved bacteriostat that costs only ⅛¢ per hand wash. It is low cost because Germa-Medica is highly concentrated and is diluted with four parts of water before use. After dilution, tests prove that daily three-minute scrubs reduce the bacteria count well below safe levels and keep it down.

Put Germa-Medica in your soap dispensers throughout the hospital now. It's the cheapest insurance against the spread of contagion you can buy.

GERMA-MEDICA®

LIQUID SURGICAL SOAP WITH HEXACHLOROPHENE

HUNTINGTON LABORATORIES

HUNTINGTON, INDIANA

PHILADELPHIA 35, PA. TORONTO 2, ONTARIO

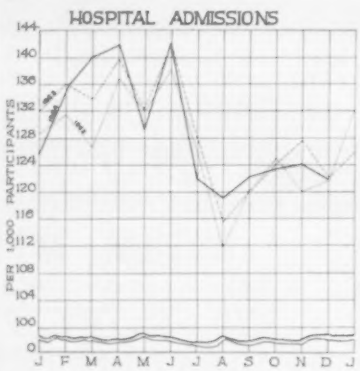
Coördination of Activities. Close liaison is maintained with the AHA Council on Prepayment Plans and Hospital Reimbursement.

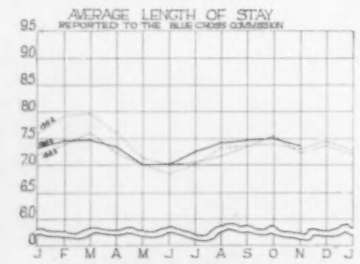
Appoint J. W. Castellucci To Blue Shield Post

The appointment of John W. Castellucci as executive director of the Blue Shield Commission, national coördinating agency of the 77 Blue Shield, voluntary, nonprofit, medical care plans, was announced February 14 by Dr. L. Howard Schriver, president of the Blue Shield Commission.

MR. CASTELLUCCI

Mr. Castellucci, formerly assistant director of Michigan Medical Service (Blue Shield), Detroit, has been with Blue Shield since 1943. He has been active both in organizing plans throughout the United States and in establishing programs to assure the efficient operation of Blue Shield plans.





ADMISSION-STAY

The admission rate during December 1954 was 122 inpatients per 1,000 members. This marks a decrease of ten per 1,000 members over the experience of the previous month.

The average length of stay for hospitalized Blue Cross members decreased from 7.50 days in October to 7.37 days in November.

Blue Cross plans provided an average of 917 inpatient days per 1,000 members in November. This marks an increase of three days per 1,000 members over the October experience.

Expect 600 Personnel to Attend Blue Cross-Blue Shield Meet

Gardner Cowles, editor of *Look* magazine, will give the major address during a special 25th anniversary banquet at the annual Conference of Blue Cross and Blue Shield Plans, to be held March 20-24 at the Edgewater Beach Hotel in Chicago.

The anniversary banquet will highlight the four-day meeting which is expected to bring an estimated 600 Blue Cross and Blue Shield executive personnel.

Discussions on major policies of both the Blue Cross and Blue Shield Commissions will be held during the sessions.

The final business item on the agenda for the conference will be the election of a delegate and alternate to the House of Delegates of the American Hospital Association and the election of officers of both the Blue Cross and Blue Shield Commissions.

CURRENT LISTING OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

ARIZONA
Phoenix—The Franklin Hospital

ARKANSAS
Prairie Grove—Elizabeth Hospital

CALIFORNIA
San Diego—Villa View General Hospital

ILLINOIS
Champaign—Cole Hospital

MICHIGAN
East Lansing—Michigan State College Hospital

NEW JERSEY
Westwood—Pascack Valley Hospital

NEW MEXICO
Silver City—Watts Clinic and Hospital

NEW YORK
Poughkeepsie—Samuel and Nettie Bowne Hospital

OKLAHOMA
Pryor—Grand Valley Hospital

PENNSYLVANIA
Palmerton—The Palmerton Hospital

SOUTH DAKOTA
Rapid City — Black Hills Rehabilitation Center, Inc.

TEXAS
Austin—Central Office, Board for Texas State Hospitals and Special Schools
Karnes City—Karnes County Hospital
Pasadena—Southmore Hospital and Clinic

WEST VIRGINIA
Parkersburg—St. Joseph's Hospital

PERSONAL

Binnig, Richard F.—Student—Northwestern University—Chicago

TWO DROPS AND ODOR STOPS!

RX54 neutralizes all hospital odors instantly — either from the dropper cap or wick setting. Unconditional money back guarantee. *Write for name of your dealer and FREE sample to — Department "C"*

SPLAIN & LLOYD, INC., Milford, Ohio

Manufacturers of SANI-SWAB

Cotton Tip Applicators for the Medical Field

FACTS...

you can prove for yourself

Regardless of Price

ACME super **DOUBLE LOCK** combination Pads and Rolls are *the most efficient available!*

- **For Quantitative Absorbency**
- **For Quickness in Action**
- **For Softness and Cleanliness**

Combining a highly absorbent long fiber cotton and a non-absorbent cotton backing, or made of 100% all absorbent cotton, Acme's combination pads and rolls have passed all tests in leading hospitals from coast to coast.

Available in a complete range of sizes.

Write for samples and technical data for your own testing purposes.

ACME COTTON PRODUCTS, INC.

245 FIFTH AVENUE, NEW YORK 16, N. Y.

Manufacturers of a complete line of high quality surgical dressings.

Bonadonna, Salvatore Stephen — Aeromed Evacuation Liaison—USAF Med. Service—6481 Aeromedical Evacuation Group—APO 704—San Francisco

Bradley, Donald Alson—Student—Columbia University—School of Public Health—New York City

Brooke, Raymond W. — Adm. — Wyckoff Heights Hospital Society of Brooklyn, N.Y.

Chandler, Lawrence Urban—Acting Adm. — National Sanitorium of Honduras — Tegucugalpa, Honduras, Central America

Crank, James E.—Asst. Adm.—Jefferson-Hillman Hospital—Birmingham, Ala.

Forche, Arthur C. — Asst. Supt. — Beyer Memorial Hospital—Ypsilanti, Mich.

Herman, James J. — Central Service & Transportation Orderly—Passavant Hospital—Chicago

Hippensteel, Donald M.—Student—Northwestern University—Chicago

Kalionzes, Gus W.—Partner—Walker, Kalionzes, and Klingerman, Architects—Los Angeles

Kerbs, Jeanne E.—Founder & Trustee—Kerbs Memorial Hospital—St. Albans, Vt.

Leclercq, Robert—Chef des Services Administratifs de l'Institut Jules Bordet—Centre des Tumeurs de l'Universite Libre de Bruxelles—Brussels, Belgium

MacKney, Joseph C.—Hosp. Adm. Off.—Dept. of Medicine & Surgery—Va Central Office—Washington, D. C.

Maifeld, Robert J.—Student—University of Pittsburgh

Mayberry, Lt. Frank L.—Student—Northwestern University—Chicago

Oglesby, James F.—Bus. Mgr.—Franklin Hospital—San Francisco

Overland, Oscar H. — Adm. — St. Luke's General Hospital—Bellingham, Wash.

Regan, William A. — Hospital Counsel — Rhode Island Hospital—Providence

Richardson, Alfred Howard — Adm. — The Finley Hospital—Dubuque, Iowa

Shortliffe, Dr. Ernest C.—Asst. Dir.—Hartford (Conn.) Hospital

Sister Alice Mary (Leary)—Asst. Adm.—St. Francis Hospital—Hartford, Conn.

Sister Mary Agnes (Curran)—Coördinator—Sisters of St. Joseph Hospitals—Wichita, Kans.

Sister Mary Madeleine — Asst. Adm. — St. Francis Hospital—Hartford, Conn.

Speer Jr., Eugene E.—Hosp. Adm. Off.—VA Central Office—Washington, D. C.

Starks, Lt. Col. Leslie E.—Student—Med. Field Service School—Fort Sam Houston, Texas

Steele, Frank J.—Chief Phar.—The Greenwich (Conn.) Hospital Association

Tribble, 1st Lt. William David,—Adm. Asst. — Director of Hosp. Services — 2750th USAF Hospital — Wright Patterson Air Force Base, Ohio

Vaughan, James M. — Adm. Asst. — The Sheppard & Enoch Pratt Hospital—Towson, Md.

Weingartner, Richard A.—Asst. Dir.—Passavant Memorial Hospital—Chicago

Wittenstein, Robert P. — Dir. of Pers. — Jewish Hospital of Brooklyn, N. Y.

NEW AUXILIARY MEMBERS

Crittenden Memorial Hospital Auxiliary—West Memphis, Ark.

Auxiliary to the Crawford W. Long Memorial Hospital—Atlanta, Ga.

St. Anthony Hospital Auxiliary — Carroll, Iowa

The Women's Auxiliary of Crownsville (Md.) State Hospital

McLaren General Hospital Auxiliary — Flint, Mich.

Bethesda Hospital Guild—Crookston, Minn.

Stone County Hospital Auxiliary—Wiggins, Miss.

St. Joseph Hospital Auxiliary—Kirkwood, Mo.

St. Mary Hospital Auxiliary — Scottsbluff, Nebr.

Women's Auxiliary Association — Community Memorial Hospital — Toms River, N. J.

Women's Auxiliary—Moses Ludington Hospital—Ticonderoga, N. Y.

Woman's Auxiliary—Yonkers (N. Y.) General Hospital

Volunteer Council of Aultman Hospital—Canton, Ohio

Franklin (Pa.) Hospital Auxiliary

Women's Auxiliary of Leahi Hospital—Honolulu, Oahu, Hawaii

Hospital association meetings

(Continued from page 6)

Institute on Obstetrical Nursing—May 16-19; Chicago (Knickerbocker)

Institute on Hospital Auxiliaries—May 19-20; Chicago (Knickerbocker)

Institute on Credit and Collections—May 23-24; Atlantic City (Dennis Hotel)

Institute on Operating Problems of Small Hospitals—May 23-24; Birmingham, Ala. (Dinkler-Tutwiler)

Institute on Operating Problems of Small Hospitals—May 26-27; Charlotte, N.C. (Hotel Charlotte)

Hospital Planning Institute and Workshop—May 30-June 3; Houston (Shamrock)

Institute on Public Relations—June 6-10; Chicago (Knickerbocker)

Workshop on Methods Improvement—June 6-10; Wilmington (DuPont)

Institute on Operating Problems of Small Hospitals—June 8-10; Huron, S.D. (Marvin Hughitt)

Institute on Central Service Administration—June 13-16; Montreal (Sheraton-Mt. Royal Hotel)

Institute on Hospital Pharmacy—June 13-17; Chicago (University of Chicago)

Institute on Accounting and Business Practices for Small Hospitals—June 27-July 1; Atlanta (Emory)

Research in function and design

(Continued from page 102)

think type plans or standards can be useful. I think they can; and you have the magnificent work of the United States Public Health Department and of my friend, Marshall Shaffer, to prove it. I think, however, that it is wrong for a body that carries out research of the sort I have been describing, itself to be responsible for the issue of type plans or standards. I think so because type plans and standards are inevitably, to some extent, instruments of national economic policy.

This is to say that, besides utilizing available research material, type plans and standards must also take into account many other factors outside the field of research. If a research body itself issues standards, it implies that the standards are derived from the research. As they never can be completely derived from research, this is undesirable. It is a good old principle of military organization that the intelligence service should be divorced from command in the field, and I think the principle is sound. ■

Only the patented

NipGard TRADEMARK

DISPOSABLE NIPPLE COVERS . . .

Offer this Simplicity and Security

Illustrations show speed and security afforded by NipGard* protection to nursing bottles:

1. Identification and formula data is written on cover.
2. Quickly applied to nipple . . . saves nurse's time. Covers nipple & bottleneck!
3. Exclusive patented tab construction fastens securely to nipple.

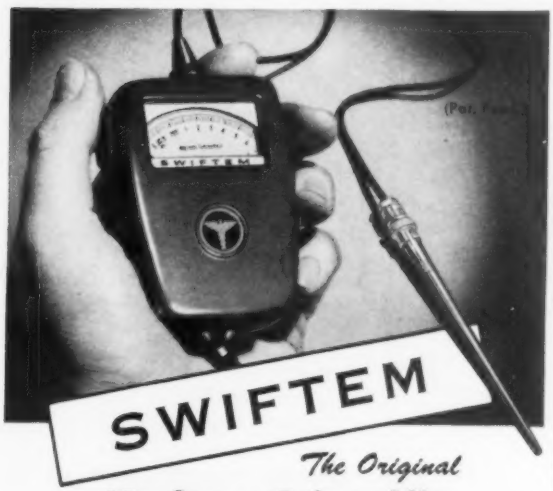
Does not jar off . . . no breakage. Used extensively by hospitals requiring terminal sterilization. Professional samples on request. Order through your hospital supply dealer.

Use *No. 2* NipGard for narrow neck bottle . . . use *No. H-50* NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.

ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS

*PATENTED

THE QUICAP COMPANY, Inc.
110 N. Markley St. (Dept. T)
Greenville, South Carolina



SWIFTEM

The Original

Modern Scientific Temperature Indicator

A new electronic thermometer designed after months of working with physicians, dentists, veterinarians and nurses . . . pocket size . . . light weight . . . fast . . . accurate . . . rugged and dependable. Pays its way by reducing loss and breakage. See your supply house or write

Burlington

BURLINGTON INSTRUMENT COMPANY
140 N. Third Street
Burlington, Iowa

STOP "HOSPITAL SMELL"

this easy, inexpensive way

AIREACTOR SPACE DEODORIZER
NATURE'S PRESCRIPTION FOR FRESHENING AIR

It's false economy to tolerate bad odors—which are irritating to patients, visitors and staff—when it's so easy and inexpensive to keep air fresh-smelling with Aireactor.

Tests prove that Aireactor neutralizes offensive odors associated with cancer, colostomy, osteomyelitis, gangrene, cast removal, medications, etc.—also unpleasant odors in dining rooms, kitchens, basements, store rooms, laboratories, wash rooms, autopsy and animal rooms, garbage disposal rooms, etc. Yet Aireactor leaves no odor of its own.

Aireactor is a clear, non-flammable solution made from rare, non-toxic elements found in plant life. It is the culmination of several years of research to formulate *an inexpensive space deodorant* that would neutralize *all* odors commonly found in hospitals and similar institutions.

Just add one ounce of Aireactor fluid to one gallon of mop water. Or use Aireactor with air-ventilating systems, mechanical ventilators or spray guns. Also available in attractive wall dispenser, and 12-ounce wick bottle.

***Try* Aireactor**—the best solution to every odor problem. It sells for less than less effective products! It will pay you to get the full story now. Write today.

AIREACTOR CORP.
22 E. 40th St., New York 16, N. Y.

prn
PRO RE NATA

JOHN H. HAYES

This month begins the fourth year of Pro Re Nata. Thus far the publishers have not been sued because of anything printed herein; and I have managed to keep out of jail. Of course, that might mean that it is dull reading or that nobody reads it. However, it has been a most enjoyable stint for me; and in writing it I have endeavored to prove that, in addition to the many problems which always cry for solution, and the many heartaches suffered and witnessed within hospital walls, there is much of humor and of a feeling of inner satisfaction with things done well, not equalled in any other human activity; and that these are our "antibiotics" which overcome many of the unpleasant situations which all of us have to face.

I have much enjoyed your pleasant comments from time to time, as well as your letters expressing disagreement with what I have written.

★ ★ ★

This could happen: a work dodger who wanted two days added to his two weeks of vacation because his work week had been reduced from 48 to 40 hours, claiming that he had always had 96 hours off previously.

★ ★ ★

I have always found it much easier to be on time or ahead of time in doing the things I had to do, than to be late. This leads me to think that being on time is actually the lazy way of doing things.

That may sound like a paradox; but when you consider that you have to do things eventually and, if late in doing them, you also have the worry and pressure, by avoiding such worry and pressure you are doing things in the easy—or lazy—manner.

The fellow with a slow start in a race has a much harder time trying to win than does the chap who gets off to an early lead.

★ ★ ★

One of the large manufacturers has as his slogan, "Progress is our most important product." Progress results from pioneering. It is impossible to visualize the end of pioneering in hospitals—or in medicine.

★ ★ ★

One way to reduce the number of steps your nurses have to travel in caring for patients is by employing only tall nurses.

★ ★ ★

Why is medical or hospital care called a "fringe" benefit? An employee's health is important to both the worker and the employer. But when a worker thinks that because he gets such benefits beyond his pay in cash he is not paying for it, he is making a mistake. The consumer pays. The worker is a consumer. The employer who provides health care is a wholesale purchaser for the consumers—his employees.

★ ★ ★

Pat Pending, our crackpot inventor, thinks that if we added Chanel No. 5 to ether, many people would not mind being anesthetized. Others might prefer Four Roses.

★ ★ ★

I suppose someone will tell me I'm wrong; but I don't think any hospital ever sold raffle tickets in which one of the prizes was two weeks care in a private room (if required, with special nurses).

★ ★ ★

A really cautious smoker might put a regular size filter cigarette into one of those cigarette holders that use a cigarette as a filter; and then smoke a king size filter cigarette with it. I must try that sometime.

★ ★ ★

You are growing old gracefully if you are beginning to realize that other people are right a good part of the time.

★ ★ ★

You can't please everyone with the way you decorate patients'

COMPARE

the advantages of steel Youngstown Kitchens units

When checked against the highest hospital standards, Youngstown Kitchens units prove their superior advantages.

Why are they best?

Sanitation stands Number One! The value of steel is here unquestioned. Steel will not absorb odors, will not decay or rot.

The enameled finishes of steel Youngstown Kitchens units are easy to keep clean.

Flexibility in planning. Whether for the main kitchen, or for nurses' stations, the wide selection of units permits unlimited planning freedom.

Excellent for laboratory use, as well.

Low in cost. You enjoy the custom-planned kitchen facilities hospitals must have; but you get them at mass-production savings.

Youngstown Kitchens units are precision built. They go together perfectly. You get a kitchen grouping that's unified.

Compare — now

You lose nothing by making a comparison.

We will gladly see that you get all the facts about steel Youngstown Kitchens units. Let us show you how you save on installation time (complete warehousing in 87 places throughout the United States and Canada).

Write: *Sales Department, Youngstown Kitchens, Mullins Manufacturing Corporation, Warren, Ohio.*

STEEL *Youngstown Kitchens*

Sold in the United States, Canada and most parts of the world.

MULLINS MANUFACTURING CORPORATION • WARREN, OHIO

TWICE AS MANY NEGATIVES IN THE SAME SPACE

Visi-Shelf FILING SYSTEM

for

X-RAY NEGATIVES

Files x-ray negatives—

. . . in ½ the space

. . . in ½ the time

. . . at ½ the expense!

The lightweight drop-door opens quickly and easily revealing all negatives in the compartment.

The patented Facile Guide-Pull "locates" the desired negative providing faster filing service.

Write for Complete Details of this New Negative Filing System!

VISI-SHELF FILE INC.
105 READE STREET • NEW YORK 13, N. Y.

HOSPITAL and DORMITORY BEDS

with Large, Deep Drawers

HOSPITAL BED
No. S1065

Solid birch construction Width: 3'-0". Length: either 6'-5" or 6'-8". 3" rubber wheel ball bearing casters. Chest is 36" x 20" x 15".

Write for Bul. HB-54

Solid birch construction. Width 3'-0". Length: 6'-6". 1⅜" rubber wheel — ball bearing casters. Chest is 36" x 20" x 15".

Write for Bul. DB-54

DORMITORY BED
No. 1065 DB

IF YOU HAVE A "HIGH-LOW" BED REQUIREMENT . . .
Check with us on the most practical and economical solution.

EICHENLAUBS
Contract Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

E-9

The Improvement of Patient Care

A Study At Harper Hospital

By MARION J. WRIGHT

The report of a comprehensively applied study of patient care. It demonstrates statistically the extent to which every job assignment is needed in modern treatment programs.

It supplies the basic methods to be used in surveying the organization of any hospital.

Recommended by the American Hospital Association.

236 pp. **Fully Illustrated** **$5.50**

ORDER FORM

G. P. PUTNAM'S SONS, Dept. AE,
210 Madison Avenue, New York 16, New York

Gentlemen: Please send me ..... copies of Wright's IMPROVEMENT OF PATIENT CARE AT $5.50 per copy. H-1

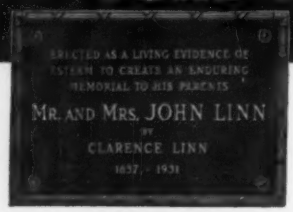
Name ..... Posititon .....

Hospital .....

Street ..... City ..... State .....

Bill me ☐ Bill Hospital ☐ Remittance Enclosed ☐

Stimulate FUND RAISING


ERECTED AS A LIVING EVIDENCE OF ESTEEM TO CREATE AN ENDURING MEMORIAL TO HIS PARENTS
MR. AND MRS. JOHN LINN
BY
CLARENCE LINN
1857 - 1931

Style B
Solid cast bronze or aluminum tablet. Raised letters in bold relief contrasting with stippled oxidized background.

Style P
Raised letter cast bronze room plaque with double line border. Available in all sizes.

Plaques & nameplates in bronze, aluminum or plastic have been proved the ideal, dignified and most effective way to raise funds for hospitals.

By acknowledging contributions in this permanent manner you encourage future donors. Why not write us now for illustrations and prices. You'll be pleased by this economical and attractive way to give permanent recognition.

A FEW OF OUR MANY HOSPITAL ACCOUNTS*

*Baton Rouge Hospital
*Cerebral Palsy Hospital
*Anderson County Hospital
*Kings Daughters Hospital
*Mt. Sinai Hospital
*Sloan Kettering Institute

*Exact addresses furnished on request

"BRONZE TABLET HEADQUARTERS"

UNITED STATES BRONZE SIGN CO., INC.
570 Broadway Dept. H New York 12, N. Y.

rooms. That's why there are so many wallpaper manufacturers.

I learned the other day that 70 per cent of the wallpaper sold today is put up by home owners and only 30 per cent by paper hangers. This reverses the percentages of a few years ago. Times change.

★ ★ ★

The best evidence of the innate kindness that is an important characteristic of most Americans is to be seen in their desire to see the underdog win.

★ ★ ★

DEFICITS: A disease peculiar to voluntary hospitals. Therapy: lots of money and good management. Can become chronic if not carefully watched.

★ ★ ★

SNAKE HOLLOW HOSPITAL NOTES:

Mrs. Sophie Kratzmeyer has donated a beautiful couch to our Psychiatric Clinic. Said she was tired of seeing her husband lying on it.

Ralph Q. Bones, while awaiting the arrival of his newborn son, made $37 by rolling dice in the expectant fathers' waiting room. This, with his Blue Cross allowance, almost paid the hospital bill.

The doctors are now being charged 10 cents per day for each unfinished patient's history, beginning with ten days after discharge. The income will be used to buy new furniture and files for the record room.

Luke Thomson, genial umpire at the local baseball park, called at our Eye Clinic the other day and was fitted for new glasses.

One of our local wits said that some of the recent election speeches by candidates could well be sent to our Speech Clinic. They were in plenty need of doctoring.

Our new trustee, Mr. Frisby, wanted to know where he could attend a course for hospital trustees. Unfortunately, there aren't any.

Our welfare commissioner wanted to know why he had to pay twice as much per day for his wife's hospital care as he pays us for welfare cases.

★ ★ ★

This would be much easier to produce if I had more brains. ■

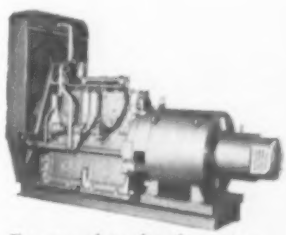
Carol—Edna—Hazel . . . did *their* warnings provide THE TIME NEEDED . . . for EVERY safeguard . . . EVERY precaution?

Temporary expediency *will not* guarantee essential lights and power.

That's why, schools, hospitals, prisons, banks, hotels, institutions and public buildings of every type are installing the dependable and rugged "automatic" standby power of United States Motors Engine-Generators.

Lights, refrigeration, elevators, incubators . . . your entire electric requirements can be insured with a U. S. Motors Automatic Standby Power Plant.

In new installations . . . U. S. Motors can supply standard models, gas or diesel for your requirements. For special conditions, U. S. Motors Engineers *will build* units to your specifications.



For complete details, write:

UNITED STATES MOTORS CORPORATION

336 Nebraska St.

Oshkosh **Wisconsin**

ADVERTISERS INDEX

MARCH 1955

Abbott Laboratories ... 31, 114, 115
Acme Company, Inc ... 191
Adams & Westlake Company, The ... 21
Aireactor Corporation ... 193
Air Shields, Inc. ... 29
Aloe Company, A. S. ... 123
American Gas Machine Company ... 38
American Hospital Supply Corp. ... 19
American Laundry Machinery Co. ... 16
American Optical Company ... 179
American Safety Razor Corp. ... 159
American Sterilizer Company ... 39
Ames Company, Inc. ... 30
Angelica Uniform Company ... 129
Armstrong Co., Inc., The Gordon ... 113
Aseptic-Thermo Indicator Co. ... 201

Baker Linen Co., H. W. ... 48
Bard, Inc., C. R. ... 64, 65
Bard-Parker Company, Inc. ... 170
Barnstead, Still & Sterilizer Co. ... 165
Bauer & Black ... 53
Baxter Laboratories, Inc. ... Third Cover
Becton, Dickinson & Company ... 49
Blickman, Inc., S. ... 139
Bolta Company, The ... 9
Bristol Laboratories, Inc. ... 22, 23
Burlington Instrument Company ... 193
Burton Mfg. Company ... 44

Cambridge Tile Mfg. Company ... 10, 11
Carnation Company ... 173
Carolina Absorbent Cotton Co. ... Facing Page 174
Celotex Corp. ... 119
Central States Paper and Bag Co. ... 171
Chamberlin Co. of America ... 37
Chicago Dryer Company ... 147
Chicago Hardware Foundry Co., The ... 187
Clean-Rite Products ... 202
Coca-Cola Company ... 185
Colgate-Palmolive Company ... 153
Continental Hospital Service, Inc. ... 186
Crane Company ... 34, 35
Cutter Laboratories ... 111

Darnell Corporation ... 166
Davis & Geck, Inc. ... 43
Deknatel & Son, J. A. ... 184
Detroit Steel Products Co. ... 58
Diack Controls ... 12

E & J Manufacturing Co. ... 175
Eastman Kodak Company ... 161
Eichenlaubs ... 196
Eisele and Company ... 185
Estey Metal Products, Inc. ... 201
Ethicon, Inc. ... Facing Page 16

Fairchild Camera and Instrument Corp. ... 42
Faultless Rubber Company, The ... 57
Fleet Co., Inc., C. B. ... 155
Flex-Straw Company ... 167

General Electric Co., X-Ray Dept. ... 24, 25
General Foods Corp. ... 133, 141
Gennett & Sons, Inc. ... 149
Goder Incinerators, Joseph ... 174
Gomco Surgical Mfg. Corp. ... 41
Goodrich Co., The B. F. ... 5
Grinnell Company, Inc. ... 4

Haney & Associates, Charles A. ... 151
Hardy Company, James G. ... 192
Harold Supply Corp. ... 201
Hill-Rom Company, Inc. ... Facing Page 158
Hillyard Chemical Company ... 7
Hobart Mfg. Company, Inc. ... 137
Hoenig & Ginters ... 201
Hoffmann-LaRoche, Inc. ... 66
Huntington Laboratories, Inc. ... 190
Hydraxtor Company, Div. of Zeypher Laundry Mach. Co. ... 145

International Nickel Co., Inc., The ... 156

Jarvis & Jarvis ... 177
Johnson & Johnson ... 50, 51
Johnson Service Company ... 117

Kohler Company ... 149

Lakeside Laboratories, Inc. ... 13
Lawson Associates ... 181
Lederle Laboratories ... 1
Lilly & Company, Eli ... 2
Liquid Carbonic Corporation ... 154

Macalaster Bicknell Parenteral Corp. ... 189
Magic Chef, Inc. ... 135
Mallinckrodt Chemical Works ... 126
Marvin-Neitzel Corp. ... 187
Massingill Co., S. E. ... Second Cover
Massillon Rubber Company ... 180
Maxwell House Coffee ... 141
McKesson Appliance Co. ... 45
McKesson & Robbins, Inc. ... 63
Mead Johnson & Company ... 17
Mealpack Corporation ... 46
Melchair, Armstrong, Dessau Co., Inc. ... Facing Page 142
Minneapolis-Honeywell ... 26, 27
Minnesota Mining and Manufacturing Co. ... 56
Mueller and Company, Inc. ... 152
Mullen Mfg. Corporation ... 195

National Cylinder Gas Co. ... 47
Norris Dispensers, Inc. ... 189

Ohio Chemical & Surgical Equipment Co. ... 55
Onan & Sons, D. W. ... 59

Parke, Davis & Company ... Fourth Cover
Parking Corporation of America ... 182
Pharmaseal Laboratories ... Facing Page 32
Physicians & Hospital Supply Co. ... 194
Pioneer Rubber Company ... 33
Polar Ware Company ... 28
Powers Regulator Co. ... 61
Procter & Gamble ... 36
Putnam & Sons, C. P. ... 196

Quicap Co., Inc. ... 193

Ritter Company, Inc. ... 62
Ross, Inc., Will ... 52

St. Charles Mfg. Company ... 121
Shampaine Company ... 183
Simmons Company ... 125
Smith & Underwood ... 12
Squibb & Sons, E. R., Div. of Mathieson Chemical Corp. ... 60
Splain & Lloyd ... 191
Swartzbaugh Mfg. Company, The ... 163

Tamblyn & Brown, Inc. ... 169

Unipress Company, The ... 15
U. S. Bronze Sign Company, Inc. ... 196
U. S. Motors Corp. ... 197
U. S. Stoneware ... 6
Upjohn Company ... 54

Vestal, Incorporated ... 176
Visi-Shelf File, Inc. ... 196
Vollrath Company, The ... 172

Winthrop-Stearns, Inc. ... 32

MARCH—1955

CLASSIFIED ADVERTISING

A. *Classifications:* Classified advertising accepted to run under the following headings: 1—Services; 2—Instruction; 3—Wanted; 4—For Sale; 5—Positions Wanted; 6—Positions Open; 7—Miscellaneous.

B. *Transient Rate:* Twenty cents a word; minimum charge $3.50 per insertion.

C. *Contract Rate:* Six-point body lines, 13 pica columns, $1.00 per line; eight-point display lines $1.20 per line. Five per cent discount for six-insertion contracts with no change of copy.

FOR SALE

DAHLBERG coin - operated PILLOW RADIOS for sale. Very little used, guaranteed $35.00 each F.O.B. Wm. G. Stevens, 820 No. Shore Dr., Miami Beach 41, Fla.

SERVICES

THE ABBOTT REFERENCE REGISTRY
Hobart, Indiana

—a lifelong reference service to professional and technical personnel.

No charge for placement. Whether seeking employment now or not, establish a permanent professional file. Safeguard your reference—have a complete, up-to-date transcript available always. Write for details.

WANTED

3 Salesmen by 64 year old national company specializing in the manufacture and distribution of Hospital Textiles. Territories—Indiana, Kentucky, Illinois, Wisconsin, Kansas, Nebraska and Iowa. Must have experience in selling hospitals. Must be willing to travel. Substantial guaranteed salary and expenses, plus profit sharing plan. Give details and send snapshot. Confidential.

RHOADS & COMPANY
401 North Broad Street
Philadelphia 8, Pennsylvania

POSITIONS OPEN

MEDICAL DIRECTOR. North American Graduate, five years Tuberculosis experience, relatively new 100 bed tuberculosis hospital, Madisonville, Kentucky. Salary $10,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

REGISTERED MEDICAL LIBRARIAN to head department of 275 bed voluntary, non-profit J.C.A.H. approved hospital. Department requires organizational and administrative ability. Active Medical Record, Medical Audit and Tissue Audit Committees. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

REGISTERED TECHNICIAN for 245 bed general hospital at St. Joseph Hospital in Lorain, Ohio. Salary open. Write to pathologist for details. Address Box F-70, HOSPITALS.

ADMINISTRATORS: (a) Lay; gen hosp 600 beds, med schl affil; West Coast. (b) Lay; ass't; newly created post; 700 bed gen'l hosp, med sch affil; oppor succeed present adm, 2 yrs; req's 5 yrs exp as adm or ass't in hosp approv'd JCAH; to $11,000; lge city. (c) Lay; vol gen hosp 450 beds; med schl affil; unit impor med center; E. (d) Medical; med sch affil vol gen hosp 375 beds; lge city; E. (e) Ass't; vol gen hosp, 250 beds; apprv'd JCAH; pref one with yr's adm res & min 1 yr exp; $7200; city 500,000; univ med center; MW. (f) Lay; vol gen hosp 150 beds; lovely res coll town; opportunity pleasant living; MidE. (g) Lay or med; ass't; one of south's impor teach'g hosps; attrac city. (h) Med dir; very lge gen'l vol hosp affil several med schls; outstand'g faculty; lge city. (i) Lay; 100 bed modern gen hosp; resort area; Pac NW. (j) Admin Ass't; prefer one w/M.H.A.; lge teach'g hosp, 750 beds; univ city; MW (k) Lay; 125 bed gen'l hosp; lge city; SW. (l) Admin Dir; 370 bed gen'l hosp; univ city, 500,000. (m) Lay; sm gen'l hosp; lake resort region; Florida. (n) Exec officer; prominent hosp assoc; req's one with senior hosp exec ability; capable organizing, direct public educ program; lge city, West Coast. (o) Lay; gen vol hosp 40 beds; someone during construction to start this spring; consider man to age 50; MW. (p) Lay; 110 bed hosp open'g in Spring; convalescent & rehabil center; lge city; MW. (q) Lay; geriatric hosp 80 beds; expan prog; univ city; Canada. (r) Lay; gen'l hosp 160 beds; exc facilities; desirable univ town 200,000; MW

ADMINISTRATIVE EXECUTIVE POSTS: (a) Accountant; 300 bed gen'l hosp; about $5000; fairly lge coll twn; MW; (aa) Chief Accountant: new gen hosp 250 bds; oppor advance to ass't adm; fast growing indus area of 50,000; Canada. (b) Accountant; ability assume managerial duties in future; 350 beds, 4 hosp units; W-Coast. (c) Bus. Mgr; 9 man grp; aircond clinic; lovely twn nr Chgo. (d) Bus. Mgr; male or female; sm gen hosp; to $6000; univ med center, 600,000; MW. (e) Bus. Mgr; 250 bed hosp; med sch affil; $6-$7000; S. (f) Comptroller; new hosp, 200 beds, opening October; work under outstand'g administrator; excel Board; twn 100,000; S. (g) Comptroller; qual in hosp accounting; 250 bed vol gen hosp; expansion program; coll twn, 65,000 MW. (h) Comptroller; 250 bed vol gen hosp affil med sch; city 115,000; E-Coast. (i) Office Mgr.; exp'd credit & collections; 125-bed vol gen hosp; consider male or female to age 50; scenic twn 25,000; MW. (j) Personnel dir & Admit Officer; estab new dept; 350-bed gen hosp; coll twn; SE. (k) Personnel & Public Relations; 455-bed gen'l hosp; med & cultural center; MW. (l) Purchasing Dir; hosp exp'd; consider male or female; 250-bed gen'l hosp; twn 80,000, SE. (m) Purchasing dir; able develop perpetual inventory; gen'l hosp 300 bds; fast growing indus area of 50,000; Canada.

ADMINISTRATORS—WOMEN: (a) Lay or RN; 75 bd gen hosp; to $6500; twn 20,000 nr univ city; SW. (b) Lay or RN; new hosp, constr to begin shortly; 40 bds; attrac sm twn; MW. (c) Lay or RN; 50 bd gen hosp; Fla. (d) Lay or RN; exp'd; gen hosp 150 bds; univ city; SW. (e) Lay or RN; new 100 bd convalescent hosp; attrac sal; univ med ctr; MW. (f) Lay or RN; 75 bd gen hosp; twn 30,000; W-central. (g) RN; to revise & develop univ nurs curriculum; to $7500; lge univ city; MW.

ANESTHETISTS: (a) Chief; excel equip, active surg serv; 150 bd gen hosp; attrac twn 20,000; SE. (b) By 4-man clin grp; resort twn; S-central. (c) Vol gen hosp 350 bds; univ affil; desirable city; E. (d) Apprv'd 115 bd gen hosp; excel surg staff; attrac sal; resort twn 10,000; MidE. (e) 250 bd vol gen hosp; 3 other anes & MD in dept; Smoky Mtns. (f) Chief; 300 bd hosp; expnd'g to 500 shortly; sal & full mtce; univ city; MW. (g) Gen hosp 100 bds; $550; attrac twn; Pac NW.

DIETITIANS: (a) Chief; very lge vol gen hosp; New England. (b) Chief; 100 bd orthodepic hosp; attrac resort twn; SW (c) Therapeutic; fully apprv'd 300 bd gen hosp; $375 start; city 200,000; MidE. (d) Chief; 350 bd gen hosp; excel facil; lovely city; E (e) New 350 bd univ hosp, opening soon; Calif. (f) Chief; excel equip; new 120 bd gen hosp; attrac coll twn 25,000; SE.

DIRECTOR OF NURSES: (aa) Nurs-serv & ed; 100 students, coll affil sch; lge, fully apprv'd gen hosp; to $10,000; attrac city 200,000; MidE. (a) Nurs serv; 250 bd TBc hosp; to $6000, full mtce; attrac city; E. (b) Nurs serv & ed.; 300 bd gen hosp; 90 students; excel staff & facil; about $8000; Calif. (c) Nurs serv; apprv'd 150 bd gen hosp; attrac city; Mich. (d) New 300 bd gen hosp; opening July; to $7000; desirable city; So. (e) Nurs serv; 75 bd gen hosp, opening shortly; attrac resort twn; Fla. (f) Nurs serv & ed; fully apprv'd 200 bd gen hosp; collegiate affil sch; faculty rank; twn 30,000; NW.

EXECUTIVE HOUSEKEEPERS: (a) New 225 bd gen hosp; excel facil; res suburb univ med ctr; MidE. (b) Very lge univ hosp; desirable city; Pac. NW. (c) Supervise staff of 40 empl; lge ped & maternity hosp. univ affil; E.

FACULTY POSTS: (a) Ed dir; resp only to admin; 45 students; apprv'd 200 bd gen hosp; to $7500; lovely twn 20,000; E. (b) Instr in nurs arts, ped, & OB; lge gen hosp; Hawaii. (c) Ed dir; potential 200 students; x lge teach'g hosp; to $6600; New England. (d) Asst ed dir; 500 bd univ hosp; desirable twn 100,000; So.

SUPERVISORS: (a) Various depts; 100 bd gen hosp opening soon; twn 30,000; SW. (b) OB; 45 bd unit; lge gen hosp; univ city; MidE. (c) OR; admin abil req'd; 8 rm suite; 300 bd gen hosp; Calif. (d) OR; 400 bd teach'g hosp, primarily surgical; excel facil; univ city; NW.

WHEN IN NEED OF MEDICAL OR NURSING PERSONNEL QUALIFIED TO HEAD DEPARTMENTS OR FOR ANCILLARY STAFF APPOINTMENTS PLEASE WRITE US FOR RECOMMENDATIONS. We offer you our best endeavors—our integrity—our 59 year record of effective placement achievement. STRICTLY CONFIDENTIAL.

THE MEDICAL BUREAU
M. Burneice Larson—Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS: (a) Medical; teaching hospital, 800 beds; extensive building program; leader of experience qualified to direct entire medical center required. (b) Medical; 300-bed general hospital; teaching program; university city, Pacific Coast. (c) Voluntary general hospital, 275 beds; expansion program; challenging opportunity; New England. (d) Assistant medical; new 500-bed teaching hospital; Northwest. (e) Medical or non-medical; 425-bed general hospital; unit, university group; East. (f) Voluntary general hospital, 135 beds; Pacific Northwest. (g) Medical or non-medical to serve as consultant, voluntary organization, 5000 beds; foreign assignment, three years; knowledge of Spanish or French required. (h) General hospital, 125 beds; Southwest. (i) Assistant by medical administrator, large teaching hospital; attractive city; young medical or non-medical administrator considered. (j) Assistant; preferable one strong in public relations or personnel administration; 700-bed general hospital; East. (k) Clinic manager; 27-man group. H3-1.

ADMINISTRATORS — (PROFESSIONAL NURSES): (a) Assistant administrator in charge of nursing service; voluntary general hospital, 175 beds; building program; residential town, Midwest; $6000, apartment. (b) New hospital, 50 beds; resort town, South. H3-2

ANESTHETISTS: (a) General 175-bed hospital; college town, Pocono Mountain area; short distances, New York City,

CLASSIFIED ADVERTISING

MEDICAL BUREAU—(Cont'd)

Philadelphia; $5400. (b) Voluntary general hospital, 400 beds, modern in every way; attractive city, outside US; mild pleasant climate. (c) Relatively new hospital, 200 beds; suburb, large city, Midwest; $6-$7000.

DIETITIANS: (a) Chief; university hospital; plans completed for new medical center including 500-bed hospital, medical school. (b) General hospital, 150 beds; residential town near Seattle. (c) Research hospital; formerly luxurious hotel; winter resort, South. H3-4

DIRECTORS OF NURSING: (a) Dean, program for graduate nurses only; preferably one with doctoral degree. (b) Voluntary general hospital, 400 beds; 180 students; collegiate affiliations; $8-$10,000. (c) General hospital, 300 beds, currently under construction; key personnel now being selected; attractive residential town, near Coast, Southeast; $8000. (d) Fairly large general hospital; 170 students; interesting city outside US; although tropical country, mild pleasant climate. (e) Beautiful new hospital, 300 beds; staff of outstanding specialists, faculty members, medical school; university and resort city. (f) General hospital, 200 beds; well endowed, foreign city knowledge of Spanish or French requested. (g) Nursing service; general hospital, 350 beds; New England; $6000-$8000. (h) Nursing service; new 7½ million dollar hospital; unit, university group; West. H3-5

EXECUTIVE HOUSEKEEPER (a) New 100-bed hospital; college and resort town, Southwest. (b) General 450-bed hospital, unit, university group; large city, medical center, East. H3-6

EXECUTIVE PERSONNEL: (a) Chief accountant qualified to direct business office; 250-bed hospital currently under construction; completion October; key personnel now being selected; college town, South (b) Purchasing director; new 300-bed hospital; Canada. (c) Food service manager; 250-bed hospital; staff includes therapeutic dietitian; costal city, South. H3-9

FACULTY POSTS: (a) Pediatric, maternity and nursing arts instructors; beautiful modern hospital; general, 400 beds; 170 students, mostly Orientals; attractive city outside U.S. (b) Educational director; 425-bed general hospital; $5500-$6600; New England. (d) Assistant nursing arts instructor and assistant instructors in medical-surgical, obstetrical and pediatric nursing; collegiate school; college town, Midwest; $4500-$5000. (e) Educational directors for Iran, Iraq, Eritres, instructors in pediatrics for Brazil, India, psychiatric for Brazil, pediatric and obstetrical for Guatemala, public health and tuberculosis for Panama. H3-7

RECORD LIBRARIANS: (a) Chief; university hospital; plans completed for new medical center including 500-bed hospital, medical school. (b) Chief; qualified to reorganize department, 400-bed hospital; unit, university group; medical center, East; attractive proposition. H3-8

SUPERVISORS: (a) Obstetrical; 475-bed general hospital; collegiate affiliations; 65-bed obstetrical unit; residential town, short distances, several large cities, East (b) Operating room; voluntary general hospital, 350 beds; service mainly surgical; medical center, Midwest; $5000. (c) Medical-surgical; important hospital; San Francisco area. (d) Operating room, obstetrical, pediatric and psychiatric; beautiful modern hospital; expansion program recently completed; resort city, South. H3-10

THE AMERICAN NURSES' ASSOCIATION
PROFESSIONAL COUNSELING AND PLACEMENT SERVICE

offers complete credentials on qualified nurses. Selective referral of nurses to positions results in satisfied staff, decreased turnover and better nursing service. Consult your State Nurses Association or the ANA PC&PS Office in Chicago.

37 South Wabash Avenue
Chicago 3, Illinois
(Tel. STate 2-8883)

SHAY MEDICAL AGENCY
55 East Washington Street
Chicago 2, Ill.
Blanche L. Shay, Director

DIRECTORS OF NURSING: (a) Middle West. 425 bed hospital. 36 month school of nursing program; average enrollment about 95. $8000-$10,000. (b) East. 100 bed hospital. Nursing school accredited. Enrollment averages 45. $6000 plus maintenance. (c) South. 225 bed hospital in city of 25,000. Close to seashore and mountains. $7200. (d) Middle West. 100 bed hospital with expansion program under way to increase to 200 beds. Excellent staff. No nursing school. $7200. (e) East. 210 bed hospital located in city of 50,000. New nursing home. $6000-$7200 plus a very nice suite of rooms.

DIETITIANS: (a) Chief. Middle West. 125 bed hospital in pleasant community of about 20,000. Dietary department is completely new with all modern facilities. $5400. (b) Assistant. East. 500 bed hospital. 100 in department. $4800. (c) Therapeutic. 325 bed hospital. Some teaching. 4 in therapeutic department. $4200. (d) South. Administrative. 500 bed teaching hospital. 130 employees in department. Food service decentralized. $6000. (e) West. 250 bed general hospital, fully approved. 45 employees in department. Duties: instruction of student nurses and supervision of special diet kitchen. $4800. (f) A food management organization has taken over the dietary departments of quite a few hospitals and needs dietitians to supervise the dietary service in each individual hospital. Positions offer excellent salaries, congenial associates and unlimited opportunity for advancement. Salary to $6500.

PHARMACISTS: (a) West. Chief. 150 bed general hospital; expansion to 200 beds almost completed. Pharmacy is completely new and modern. $525. (b) East. Chief. 225 bed general hospital, fully approved. $450. (c) Middle West. 175 bed hospital located in pleasant community close to several large cities. $400. (d) Middle West. 350 bed hospital in University town. 4 in department. $400. (e) East. 150 bed hospital ideally located in beautiful resort area. Duties will also include supervision of Central Stores and Purchasing. $6500.

MARY A. JOHNSON ASSOCIATES
AGENCY
11 West 42 Street New York 36, N.Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidates, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists and other supervisory personnel.

No registration fee

HOSPITAL PERSONNEL BUREAU
Charles J. Cotter, Director
Knickerbocker Bldg. 218 E. Lexinton St.
Baltimore 2, Maryland

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Pharmacists, Nurses, Technicians, Housekeepers, Comptrollers, Accountants, Secretaries, etc., Mail resume, 5 photos.

No Registration Fee.
Licensed Employment Agency.
(Formerly Hagerstown, Maryland)

---

2 NURSE ANESTHETISTS to fill vacancies which will be created very shortly. Good salary, good working conditions. Apply Chief, Anesthesia Department, The Mercer Hospital, Trenton, N. J.

ZINSER PERSONNEL SERVICE
79 W. Monroe Street
Chicago 3, Illinois

NURSES, TECHNICIANS, DIETITIANS, PHYSICIANS, NURSE SUPERINTENDENTS and INSTRUCTORS—We can help you secure positions.

"UNUSUAL OPPORTUNITY IN CALIFORNIA FOR HOSPITAL ADMINISTRATOR"

WANTED: Administrator for substantial accredited hospital. Good background required. All applications confidential. Address: Box F-71, HOSPITALS.

HOSPITAL FACILITIES CONSULTANT—Responsible for Hill-Burton and Territorial construction programs, cooperation with Alaska Public Works construction program, and hospital licensing program. College graduation plus four years of progressively responsible governmental or business experience, of which two years will have been in an administrative or consultative capacity related to public health or hospital administration. Salary open. Write C. Earl Albrecht, M.D., Alaska Department of Health, Juneau, Alaska.

ANESTHETIST—Ideal opening on staff of three; 133 bed voluntary hospital associated with private clinic in summer-winter resort area; wide experience; salary open. Little Traverse Hospital, Petoskey, Michigan.

DIETITIAN—Assistant to Chief. General Hospital for men, women and children. Duties involve therapeutic diet planning, patient contact, assist in general supervising and some tray checking. Apply the Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

NURSE ANESTHETISTS for 150-bed general hospital; four nurses, full time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

DIETITIAN—Full charge ADA for 135 bed hospital fully approved in metropolitan area of North East Ohio. Address Box F-90, HOSPITALS.

REGISTERED MEDICAL RECORD LIBRARAIN—to head well organized department in 325 bed, non-sectarian, approved general hospital; university affiliated; successor to oldest hospital in Michigan; located in downtown Detroit. Liberal personnel policies; good working conditions; good salary. Prefer person interested in punch card statistics and microfilmed records. Apply to Administrator, Detroit Memorial Hospital, 1420 St. Antoine Street, Detroit 26, Michigan.

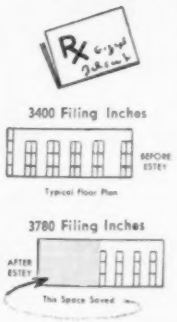
EXECUTIVE HOUSEKEEPER. 275 bed voluntary non-profit hospital with new and old section. Renovation program. Must have administrative and teaching ability. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

CHIEF LABORATORY TECHNICIAN—Qualified to supervise department of eight; 133 bed voluntary hospital associated with private clinic in summer-winter resort area; salary open. Little Traverse Hospital, Petoskey, Michigan.

DIETITIAN—110 bed hospital, salary depends on experience and qualifications. Write Administrator, Somerset Community Hospital, Somerset Pennsylvania. 60 miles east Pittsburgh on Pennsylvania Turnpike.

CLINICAL INSTRUCTORS: 1 Medical and 1 Obstetrical, for 502 bed hospital in Philadelphia area. Salary based on qualifications of applicant. Automatic salary increases. 40 hour week, 28 days vacation, 14 days sick leave. Blue Cross Plan available. Teaching duties only. Opportunity to pursue additional University courses. Apply to: Director of the School of Nursing, Cooper Hospital, Camden, New Jersey.

"RECORD FILINGITIS?" DON'T GIVE UP!



Now store twice as many records in your present floor space!

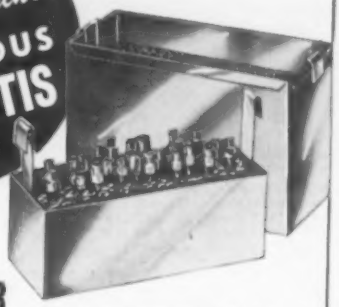
Estey has the prescription for your crowded Record Room. Used and approved by Veterans Administration Hospitals.

OPEN SHELF FILING
No Doors — No Drawers
Records accessible without *Special Expansive Guides*

Write for our complete illustrated catalog of Open Shelf Filing.

ESTEY
METAL PRODUCTS, INC.
Seven Catherine St. Red Bank, N. J.

HELP *Guard Against* INFECTIOUS HEPATITIS



Hasco NEEDLE CONTAINER

MADE OF STAINLESS STEEL

- Helps Guard Against Infectious Hepatitis.
- Protects Needle Points after use.
- Prevents Needles from Becoming Clogged.
- Efficient Method for Returning Needles to Central Supply.
- Provides Method for Handling Needles During Processing.

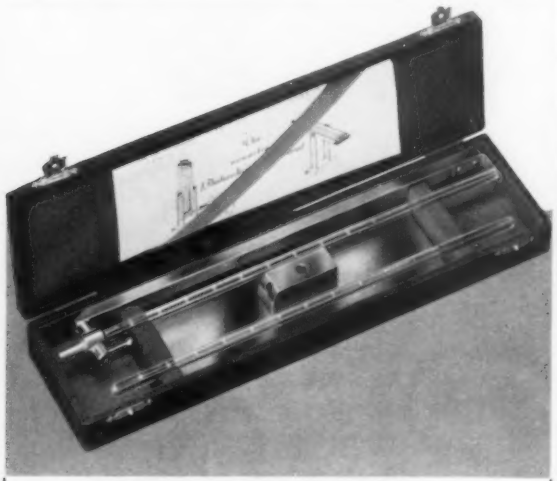
No. NC25 **$9.50 Ea.**

Lots of 6 — $9.00 Ea. Lots of 12 or more $8.75 Ea.

Send For Brochure "NA" for Full Details

HAROLD SUPPLY CORPORATION
100 Fifth Avenue, New York 11, N. Y.

90



NEW . . . 10-MINUTE
BLOOD SEDIMENTATION APPARATUS

Visita, for use in doctors' bag, with 1 pipette
$17.50

Top quality. Made in Germany. Thoroughly tested and inspected before delivery. Ten-days money back guarantee. Send for brochure.

For Laboratories

Laboranta, with 3 pipettes
$24.50

Laboranta, with 5 pipettes
$29.50

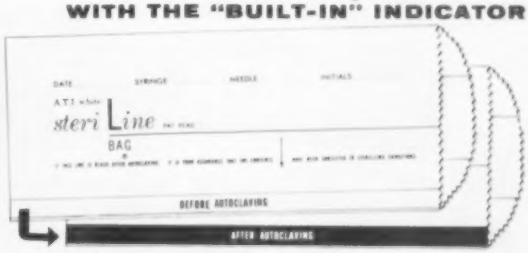
Laboranta, with 10 pipettes
$49.50

HOENIG & GINTERS
2203 Cambridge Street Los Angeles 6, Calif.

Announcing the NEW

A.T.I. *steriLine* BAG
® PAT. PEND.

WITH THE "BUILT-IN" INDICATOR



The ONLY sterilizing bag with a "steriLine Indicator"
...which changes color from white to black after autoclaving.

No longer do you have to guess whether your syringes, instruments, or needles have been autoclaved. Now, the new "steriLine Indicator" has been added! This "built-in" indicator changes color from white to black only after proper sterilizing conditions of time, steam and temperature have been met in your autoclave.

SteriLine Bags are available in usual sizes.

Test A.T.I. steriLine Bags FREE. Write today for FREE Sample steriLine Bags, literature and prices. GET ALL THE FACTS!

The steriLine Bags are a new development of the

Aseptic-Thermo Indicator Company

makers of STEAM-CLOX, COOK-CHEX and other sterilizing indicators.

11471 Vanowen Street
North Hollywood, California

STERILINE BAGS H-3
Aseptic-Thermo Indicator Company
11471 Vanowen St., No. Hollywood, Calif.

☐ Please send free samples and information.
☐ Please have service representative call.

My name _____
Title _____
Hospital _____
Address _____
City _____ Zone ____ State ____

POSITIONS WANTED

ANESTHESIOLOGIST—Diplomate; past 10 yrs successful priv prac anes, attending anes 120 bed hosp and ass't visiting anes impor tch'g hosp; seeks dir dept anes lge hosp on fee for service basis; req's warm climate; early 40's.

ADMINISTRATOR—6 yrs dir, 300 bed hosp; 2 yrs dir, 350 bed gen'l hosp; very active hosp affairs; Member ACHA.

ADMINISTRATOR—Medical; M.S., hosp adm; 5 yrs Lt. Col. USAMC; 5 yrs admin univ hosp 400 beds; Member ACHA.

ADMINISTRATOR—Clinic Manager; B.A., M.A., PhD, (Languages), M.Sc Hosp adm; 4 yrs Army Adjutant's office; 5 yrs, clinic mgr-hosp admin, hosp grp (50 beds) 2 yrs, clinic mgr, impor 11 man grp; recommended as above-average in devotion to duties, personable, co-op, with ability to meet public; Member NACM; late 30's; any locality.

ADMINISTRATIVE ASSISTANT—29; B.A.; M.S. hosp admin; completed 1 yr adm residency; 700 bed gen'l vol hosp; seeks adm assistantship hosp 200 beds up or admin hosp 50 to 100 beds.

INTERNIST—With special inter allergy & chest diseases; M.D., Virginia; Res 1 yr each med, allergy, chest; univ hosp; bd elig; 3 yrs, WWII; early 30's; recommended as being superior in every category of post-grad trn'g, having originality, excel clinical judgmnt; with sound academic background, handsome, delightful, tall young man.

PATHOLOGIST: 31; Diplomate (path anatomy-clinical path); trn'd univ hosps; exc research, academic background; since 1953 ass't chief path 1000 bed hosp; recommended as outstand'g path.

PATHOLOGIST—Trn'd univ hosp; 2 yrs ass't path 350 bed tch'g hosp; 1 yr chief path 500 bed hosp & ass't prof, path impor univ med sch; Diplomate, anatomy, elig, clinical; middle 30's.

PURCHASING DIRECTOR — Woman; 29; single; 10 yrs ass't purch agent, univ hosp 500 beds; seeks position as purch dir smaller hosp or ass't iger hosp; prefers Mid-West.

PURCHASING DIRECTOR—B.A., past 6 yrs P.D., inventory control, 200 bed hosp; fine man in late 20's; widower; seeks hosp 250-400 beds.

RADIOLOGIST—trn'd univ hosps; 2 yrs successful priv radiological prac, & assoc, dept rad & Jr attending rad sev lge hosps; early 30's; Cat. IV; Diplomate, diagnostic & therapeutic.

PLEASE SEND FOR AN ANALYSIS FORM SO WE MAY PREPARE AN INDIVIDUAL SURVEY FOR YOU. We offer you our best endeavors—our integrity—our 59 year record of effective placement achievement. STRICTLY CONFIDENTIAL.

THE MEDICAL BUREAU
M. Burneice Larson—Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR: Medical degree, Harvard; three years' teaching (medicine); two years, assistant director, teaching hospital; fourteen years, administrator, voluntary general hospital, 400 beds.

ADMINISTRATOR: M.H.A. (Hospital Administrator); five years, assistant administrator, 400-bed hospital; available for position of increased responsibility and authority.

ANESTHESIOLOGIST: Diplomate, American Board; successful private practice since 1949; interested in re-locating to obtain better primary and secondary advantages for children.

DIRECTOR OF NURSING; B.S., B.N., M.A., degrees; five years, director of nursing, 200-bed hospital; four years, assistant dean and assistant professor, university school.

PATHOLOGIST; Diplomate, (Pathologic Anatomy; Clinical Pathology); three years' full teaching; six years, director of pathology, 300-bed general hospital

RADIOLOGIST; M.D., Jefferson; three-year residency, university hospital; three years, associate radiologist, large teaching hospital, instructor in radiology, medical school; Diplomate.

CHIEF ENGINEER—Graduate Mechanical—600 bed and over. Qualified to supervise technical Engineering Staff and Mechanics of all crafts. To assume responsibility for planning new construction, major internal relocations and repair projects. Twenty years experience in all phases of maintenance of power and heating plants, air conditioning, refrigerating systems and building appurtenances. Possess special talents in the successful handling of men and planning work with minimum of interference with normal function of activities. Address Box F-91 HOSPITALS.

ADMINISTRATOR — Male—48—Ten years Hospital Trouble Shooting. Well informed on all Hospital Departments. Finishing 2½ years rebuilding large, disorganized 300-bed hospital into Accredited Hospital. Accredited last month first time in history of hospital. Best references. Prefer N.E. or Eastern part of country. Available in 90 days. Address Box 82, HOSPITALS.

PATHOLOGIST: Certified clinical and anatomic pathology. Age 38. Category IV. Associate Professor. Extensive surgical pathology, teaching, research, publications. Desire hospital appointment, prefer academic and research possibilities. Address Box F-69, HOSPITALS.

ANESTHETIST, graduate Western Reserve Hospitals, over 15 years experience; all types of anesthetics. Address Box F-93, HOSPITALS.

RADIOLOGIST—2 years assistant professor large university hospital desires own hospital department directorship. Certified in diagnosis and therapy. Age 32, Category IV, Family. Address Box F-85, HOSPITALS.

Why Pay 5¢ to 15¢ to Launder Bath Mats?

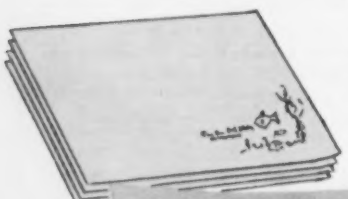
TOSS-AWAY BATH MATS

COST LESS THAN 2¢ EACH

Cut down on laundry expense, and offer patients a personal and sanitary service at the same time!

Toss-Away bath mats are far less expensive than supplying and laundering chenille bath mats. Save at least 3c on laundering alone, not to mention replacement costs.

Made of highly absorbent heavy wood-pulp paper, Toss-Away mats will not shred or tear apart even when soaking wet. Size 14"x20". And look how little they cost:



1000 Stock design shown $20.00

F.O.B. Rapid City, 3% cash discount when check accompanies order.

WRITE FOR FREE SAMPLES

CLEAN-RITE PRODUCTS
Box 1521-H Rapid City, S. D.

Yours for the Asking . . .

. . . . The 202 pages of this March Construction issue of HOSPITALS contain important messages from 131 advertisers. Each of these messages is an invitation for you to write for further information. Some furnish a coupon, others a brief mention of a catalog or product description.

To get the most out of this issue of the Journal, we encourage you to ask for further information from these reliable companies. Their help is yours for the asking.

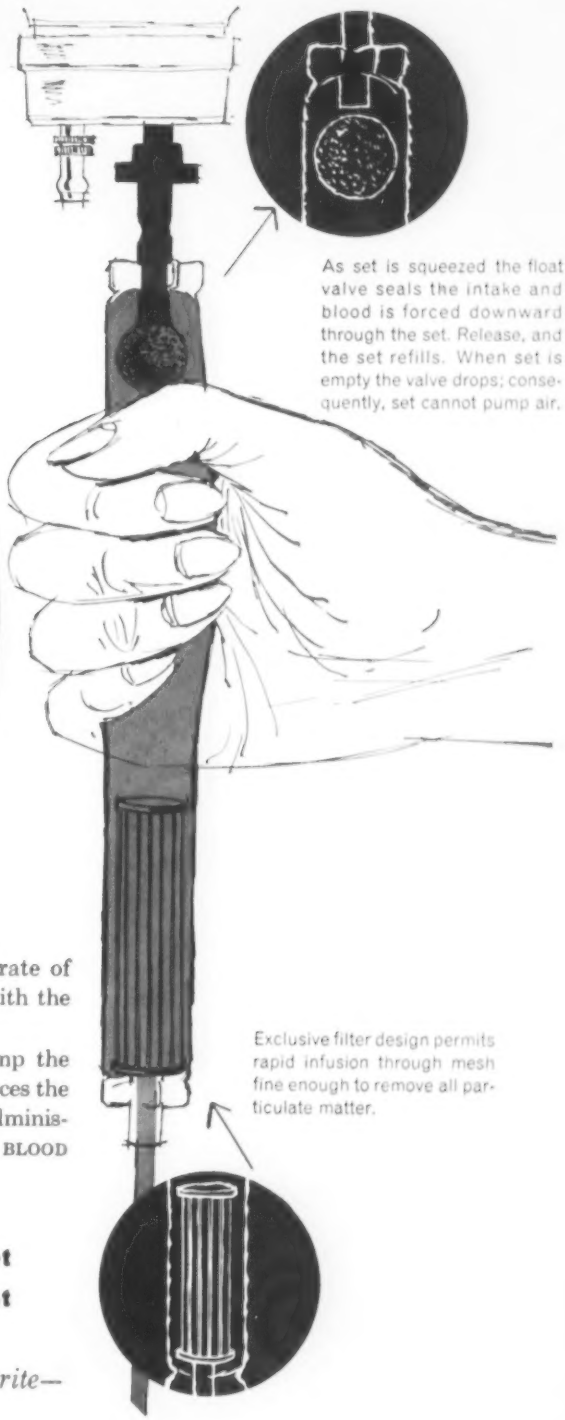
HOSPITALS
Journal of the American Hospital Association
18 E. Division St., Chicago 10

NEW

for
administering
blood under pressure
with maximum
safety and efficiency

PLEXITRON

combination
administration set
& pressure pump



As set is squeezed the float valve seals the intake and blood is forced downward through the set. Release, and the set refills. When set is empty the valve drops; consequently, set cannot pump air.

Exclusive filter design permits rapid infusion through mesh fine enough to remove all particulate matter.

IN A FEW SECONDS you can switch from the normal rate of giving blood to rapid administration under pressure with the new Plexitron R48 Expendable Combination Set.

When the need for pressure arises you merely pump the flexible drip chamber. As it fills with blood, pumping forces the blood into the patient's veins under pressure. Rate of administration is determined by the pumping action—A PINT OF BLOOD CAN BE GIVEN IN 4 TO 5 MINUTES.

PLEXITRON the right set
for every parenteral requirement

for sample set and complete information, write—

products of

BAXTER LABORATORIES, INC.

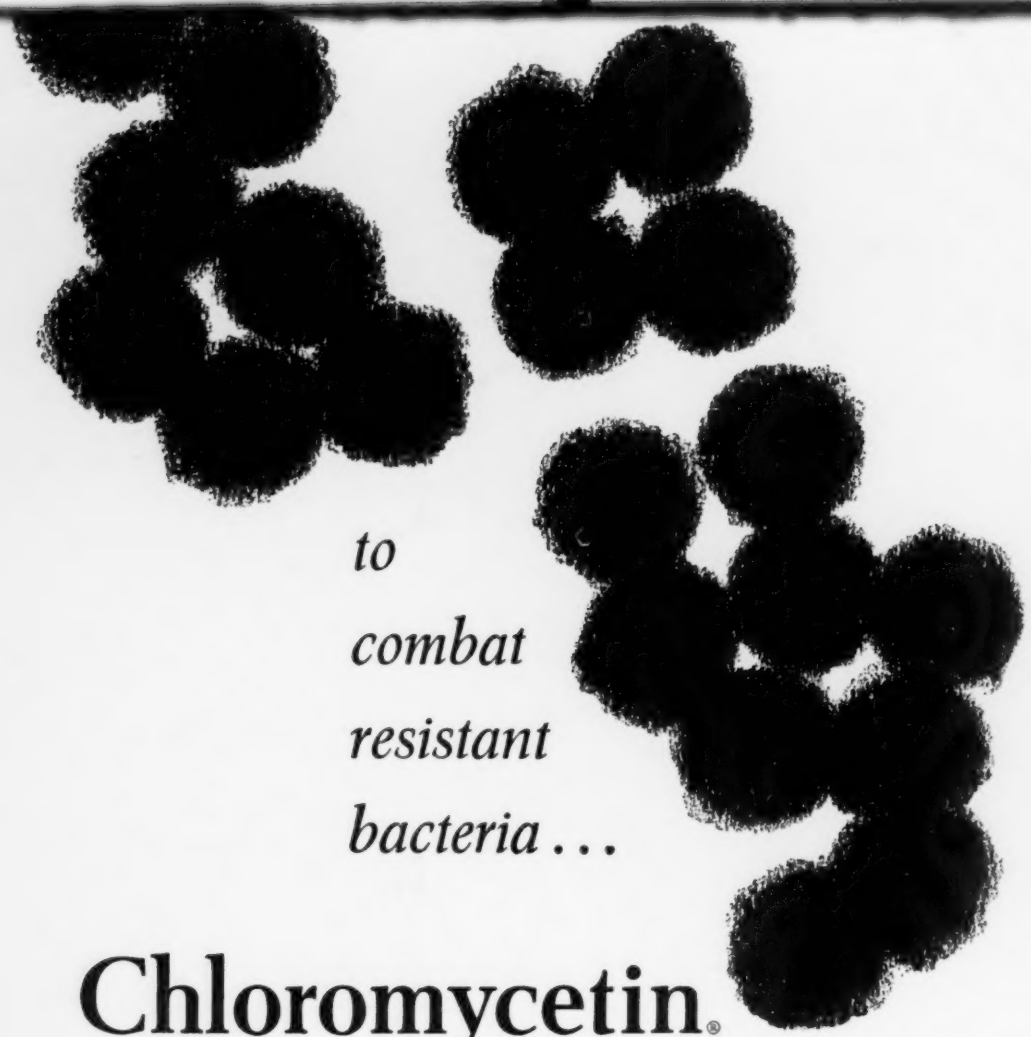
Morton Grove, Illinois • Cleveland, Mississippi

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION

GENERAL OFFICES • EVANSTON, ILLINOIS



to
combat
resistant
bacteria . . .

Chloromycetin®

The rising incidence of bacterial resistance to various antibiotics constitutes a serious therapeutic problem. Many infections, once readily controlled, are now proving difficult to combat. Administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis) is often useful in these cases because this notable, broad-spectrum antibiotic is frequently effective where other antibiotics fail.

"...An advantage of CHLOROMYCETIN appears to be its relatively low tendency to induce sensitization in the host or resistance among potential pathogens under clinical conditions."*

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN